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School Nurses and Adolescent Groups

Nutritionist in an Adolescent Clinic

Emotionally Disturbed Children

A Health Service

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AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

First aid for an emotional crisis comes to this child as the comforting arms of an adult. It may be all he needs to cope with one of the minor crises that are part of every child's daily life. But for far too many children emotional disturbance is chronic, deep, and severely handicapping. Three articles in this issue discuss programs for helping such children in the community and in school. (Pages 221, 227, and 232.)

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ADA M. DANIELS

School nurses are in a crucial position to help young people straighten out a confusion of fears, misinformation, and worries connected with the physical and emotional changes of adolescence—a confusion which often leads to tragic mistakes. Unfortunately, many nurses who work in schools are not equipped with the special skill and understanding needed to provide the kind of help confused young people require. Recognizing this fact, the Child Study Association of America (CSA), at the request of the Colorado State Department of Public Health, and with encouragement and financial support from the Children's Bureau, has been carrying out a demonstration project in Denver to train nurses in the schools to lead small groups of adolescents in discussions focused on the issues troubling them. The purpose of the project is not only to increase the nurses' skills as group discussion leaders, but also to broaden their understanding of adolescents generally and increase their ability to deal with them sensitively.

Public health nurses assigned to the schools in Denver have for some time been conducting sex education programs in the junior and senior high schools. Prior to the CSA project, these programs usually consisted solely of showing a film on menstruation to the girls and one on human growth and reproduction to both boys and girls, following the showings with brief discussions of the facts pre-

training SCHOOL NURSES to work with groups of ADOLESCENTS

sented in the films. While some of the nurses realized that many of the young people were confused about how to apply the biological information they were getting to the situations they confronted in their day-to-day lives, the nurses did not encourage discussion of the personal and social issues connected with the facts presented. The CSA project has concentrated on preparing some of these and other nurses to help young people understand better their own physical, emotional, and mental development and to make more thoughtful behavioral choices.

The project got under way in January 1966. Fourteen nurses, varying greatly in age and experience, were selected to participate in the initial training program: three school health nurses, seven public health nurses who had been assigned to part-time duty in the schools, two consultants from the State Department of Public Health, one nurse from a clinic for adolescents, and one nurse from the University of Colorado faculty. Since in the Denver public schools sex education for boys is customarily handled by a physician, all the nurse-trainees were prepared to work with groups of adolescent girls.

The "issue-focused group discussion" method was chosen as a means through which the young people, under skilled leadership, could exchange ideas about themselves and their peers, acquire correct information relating to their bodily functions and their emotional and social needs, and begin to apply this information to themselves. Since adolescents frequently have difficulty discussing their problems with adults, whether parents or teachers, a method which enables them to talk to each other about the things that bother them, under the guidance of an objective, knowledgeable adult, is especially appropriate for them.

The underlying purpose was to help the nurse-leader increase her understanding of adolescents, the issues they are most concerned about, and the range of appropriate behavioral choices available to them. These issues the project planners saw as having to do with the physiological and emotional changes adolescents are undergoing—especially those connected with puberty—and with ways of coping with them, such as personal grooming, boy-girl relations, and educational and vocational planning.

Using physiological and emotional changes as broad topical categories, the nurse-leaders were asked to suggest agenda for a series of four to eight discussion meetings of about 50 minutes each, which could serve as a framework to contain the often impulsive, scattered thinking of adolescents. Then, in practice discussion groups, they offered the young people an opportunity to select some specific issue within this framework for the focus of each session, and helped them explore the personal meaning of their questions and remarks.

To do this effectively, the nurse-trainee had to pro-

vide an atmosphere of objectivity and tolerance and draw on her knowledge about life and the complexities involved in behavioral choice as well as on her broad range of information about how the body functions and how this affects human emotions. In giving factual information, she had the use of many visual aids, but the discussion was not limited to the facts these presented, as it had been in the past.

The program design

The training program was based on a design previously used in other training programs of the Child Study Association of America.[1] This consisted of an initial 2-week institute, followed by a period of supervised field work, a 1-week followup institute, and another period of supervised fieldwork. Supervision was provided by mail and through intensive conferences with the individual trainees prior to the followup institute. Supervision by mail is, of course, an unusual method, but the training staff of the Child Study Association of America, based in New York, has had many years of experience with it.[1]

The first 2-week institute was held in January. The instructors consisted of two staff members of the Child Study Association of America aided by representatives from the Denver school system, the local welfare department, the University of Colorado Medical Center, and the University of Maryland School of Nursing. During the first week, the nurses were given a review of child development theory from early infancy to adulthood, with special emphasis on early puberty and adolescence.

The second week of the institute was devoted to the specific methods of conducting issue-focused small group discussions with adolescents. As a demonstration, the film "Human Growth and Development," often used in school programs of sex education, was shown in a local junior high school auditorium to a large group of girls, after which the nurse-trainees divided the audience into groups of 10 to 15 students each and led discussions, using the techniques to which they had just been introduced.

In these discussions, the girls confronted the nurses with 80 *different* questions, revealing worries or misapprehensions about a whole range of biological subjects, from menstruation—cramps, moods, permissible activities—to venereal disease, miscarriage, conception and pregnancy, sexual intercourse, and male physiology. For example:

"Do boys dream about sex and then wet the bed?"

"How do babies come through that small opening?"

"How do birth control pills work—don't you take them by mouth and they settle in the vagina so that when the egg comes by they swallow it?

"Why are boys more excitable sexually than girls and how can we control them?"

"Why do parents feel funny about talking to their children about these subjects?"

"Why do they wait so long before showing us these kinds of films?"

The nurse-trainees' reactions to this experience ranged from an anxious sense of being overwhelmed to a sense of elation at finally getting at what they had been feeling all along in their daily work with students: that the problems really troubling the young people who came to them were below the surface of the physical complaints they presented. Some of the nurses expressed doubt about being able to handle such emotionally charged questions within a school, with its many restrictions on what could be discussed with young people. Yet, they all expressed eagerness to learn ways of coping more effectively with the fears and misconceptions that had been so openly expressed.

While the trainees seemed to have confidence in their ability to deal with the usual kinds of questions raised in relation to menstruation and other health-related topics, many of them expressed consternation at the prospect of having to handle such delicate subjects as "the pill," abortion, and premarital sexual relations should questions around these issues arise. All, however, agreed that adolescent girls need basic information concerning their bodily processes.

Handling specific issues

Using menstruation as a topic that all the trainees felt at ease in handling, the CSA staff demonstrated how such a topic could be dealt with in a small discussion group, in contrast to the way it might be dealt with in a class on hygiene. With the mood swings of the menstrual cycle taken as an example, the trainees were helped to look at the physiological facts—hormonal changes, water retention, and so forth—that the girls needed to know about to be aware of the normal internal changes that may cause them to feel peculiar, either before or during menstruation. The nurses were helped to see that after giving the girls such factual information about mood changes, they could help them explore the feelings they experienced at these times—depression, irritability, hypersensitivity, tearfulness, negativism, withdrawal, emotional outburst, quarrelsomeness—and how these feelings could affect their relationships

with other people; and that then they could encourage the girls to express how, as individuals, they felt about menstruation—whether just "crummy," or resentful of the limitations it puts on going swimming, or deeply angry at its messiness—so that the girls would come to realize that there are many different but normal physical and emotional reactions to menstruation and both constructive and destructive ways to cope with such feelings.

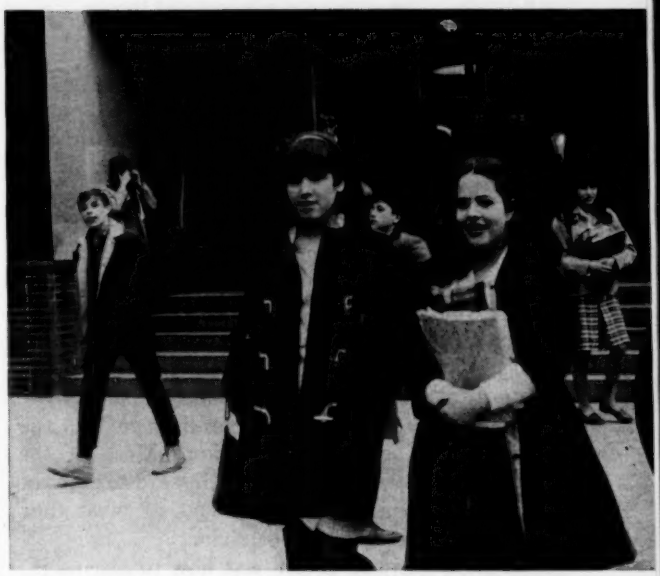
The trainees were then helped to see how they could use this kind of approach to the girls' questions regarding issues having moral implications. Questions about induced abortion, for example, could be dealt with first by giving the girls the facts about how pregnancy takes place, the medical difficulties and dangers of interrupting a pregnancy, and the emotional consequences to the girl who undergoes such an experience and to her parents. The girls could then be encouraged to consider the alternatives—what they at their age were really ready for in regard to relationships with the other sex. Similarly, questions about contraception could be dealt with in terms of the biological facts, the medical supervision necessary to make it effective, and the emotional conflicts and the behavior choices that the use of contraceptives poses for a girl.

In this way the nurses were helped to see that all the issues of crucial concern to young people—especially boy-girl and parent-child relationships—need to be explored in respect to where the girls are in their emotional and physiological development, and what they need to know and think about to move on constructively to the next phase of their lives.

Some of the nurses expressed concern about the possibility of giving information to young people that might conflict with what their parents were telling them at home. Many of the girls in the schools they were assigned to came from ethnic backgrounds having different cultural mores and beliefs from their own. For example, some of the girls had been brought up to believe it was dangerous to bathe during the menstrual period. The trainees were helped to see that a contrary view could be presented as new medical information that had not been available to the girls' mothers when they were growing up and as such would not be likely to create a family conflict.

Field practice groups

The requirement for the first supervised fieldwork training period was that each nurse lead a group of from 15 to 20 girls for from 4 to 8 weekly sessions.



Adolescents, like these high school boys and girls, are often confused by the changes they are undergoing. In Denver, school nurses are leading adolescent discussion groups to help young people understand the meaning of such changes.

Several of the nurses recruited groups in the school in which the 1-day demonstration program had taken place. Some organized groups in schools to which they were regularly assigned. A few of the public health nurses who had no regular school assignments recruited groups in parochial schools, which had previously hesitated to permit sex education programs. Others formed groups of older adolescent girls who were serving as volunteers in hospitals.

The nurse-leaders of each of these groups were supervised by mail by the CSA training staff. Each nurse-leader mailed a detailed report of each group meeting to her supervisor as soon after the session as possible, giving information on the basic content of the session, the group interaction, the leader's activity, and the problems that arose. She received in reply comments about her leadership and suggestions for handling the various issues brought up by the group members.

Most of the nurses had some initial resistance to writing reports that required so much more detail than the brief topical reports they were used to. They also had clerical problems, since the school administrators were not all prepared to give the additional clerical help or time they needed to produce the reports quickly. Despite these difficulties, the nurses were able to profit from the points made in the super-

visory responses to their reports and to improve their skill.

At the end of the first fieldwork training period, each trainee had a personal conference with her supervisor to discuss her leadership problems directly.

As had been expected, the issues brought up by the girls in these practice discussion groups fell under a few major themes. First and foremost was boy-girl relationships. This included such questions from the girls as how to behave on dates, how to handle the sexual advances of boys, and how to deal with their own needs for affection and popularity and their own sexual promptings. These questions gave the nurses an opportunity to bring in information about physical development, the facts of reproduction, and the consequences of sexual exploration. Most of the nurses learned not to moralize, but instead to help the girls think through the implications of what they were saying about their own behavior.

Next most frequent theme was how to discuss relationships with parents. Why were parents so "old-fashioned" in their thinking? Why couldn't girls go out on dates at ages 14, 15, or 16, or wear certain styles of hairdress, clothes, makeup? Why were parents so uninterested in listening to the girl's side of the story and so hard to talk to? Some girls expressed the feeling that their parents were too involved in their own daily problems to pay attention to their daughters' needs.

The nurses were usually able to help the girls recognize that many of their complaints about their parents were related to a difference in the girls' and the parents' perceptions of their maturity and their readiness to handle the kinds of experience the girls actually were having trouble with—their inability to know how to deal with a boy on a date, for example. They also helped the girls discuss ways in which they could handle conflicts with parents more constructively. During these discussions, many of the girls gave evidence of developing a more positive perception of their parents—some even to the point of sympathizing with their hard lot.

While most of the groups consisted of girls from a variety of backgrounds, two consisted chiefly of girls who had experienced severe deprivation—emotional, economic, and cultural—and who had exhibited serious behavior problems in school, truanting, getting into fights, and actual delinquent acts. Some were on probation from the court. The girls in these groups raised questions about venereal disease, pregnancy (which several of them had already experienced), parental cruelty or neglect, and their own need to rebel. At all times they were accorded support and respect by the nurse-leaders, and for the most part by the other members of their group.

With this unaccustomed acceptance and with the information and guidance given them by the nurse-leaders, some of these girls began to question the behavior choices they had made in the past and to think about the advantages of staying in school and making realistic vocational plans. Even those whose behavior in the group did not change gave evidence of more responsible behavior in school—less truanting, for example—and a growing capacity to examine their behavioral choices. The marked effect of a group experience on some of these girls caused a real stir among the school personnel, the probation officers who had tried to deal with them in other ways, and the nurse-leaders themselves.

At the end of the series of practice sessions, some nurses gave their girls questionnaires—to be returned unsigned—asking whether the meetings had been helpful. About 85 percent of them replied; all, favorably. One girl answered:

Yes, in our normal health class, we can't ask the questions that bother us or we don't understand. . . . it's really nice to have had someone who understood our feelings. . . . I mean, to know that we are human and not wild and unreliable.

All the returns gave an affirmative response to the question of whether *all* boys and girls in the 9th and 10th grades should have an opportunity to participate in such groups. Some indicated that the group sessions should take place twice a week for a semester; all, that there should be more sessions in each series than there were.

Followup program

The second part of the training program took place in April 1966, and involved a week's followup institute, preceded by intensive supervisory conferences with each trainee. In this followup period the trainees exchanged information about their experiences and raised whatever questions they had about them. They also examined records of discussion groups of adolescents from another CSA training program to study the leadership methods.

All 14 of the trainees participated enthusiastically in all or part of the followup sessions although at the beginning of the program in January some had expressed doubts about having the time to do so. As they discussed their practice group experiences, it became obvious that they had applied the lessons

from the original 2-week institute with a great deal of imagination and flexibility—in recruiting their groups, in interpreting the program to school administrators, teachers, and parents, and in leading the groups—and had made a noticeable impression on other professionals in the schools, on the parents, and on the girls. True, the degree of skill and understanding in group leadership the nurses had acquired varied with the individual. In the followup program, however, they all discussed freely their own shortcomings and areas of confusion.

Leadership problems

Certain basic leadership problems were brought out in the followup sessions.

The nurses who had led groups composed of girls from diverse ethnic and socioeconomic backgrounds had shied away from discussing subjects that would reveal differences in family customs and behavioral attitudes, regarding these as potential sources of conflict among the group members. For example, some girls from Spanish-American families were not permitted to go out with boys until a much later age than usual in most other American families. Knowing this and fearing that the girls of Spanish cultural background and their families' standards and practices would be ridiculed by the other girls, the nurse-leaders in these groups did not encourage the young people to talk about their difficulties with their parents over restrictions, although such conflicts came up in their groups as in the others.

As the reasons for this hesitancy were examined in the followup seminar, the nurses recognized that they themselves and not necessarily the girls in their groups were the ones who felt that standards different from their own were "inferior," and that a free discussion among the students about their experiences might have revealed many diverse practices in families generally, all with both positive and negative aspects. For example, the practice group discussions had revealed that many girls were permitted almost limitless freedom, with almost no parental restrictions set on their behavior, and that the girls themselves often attributed this to lack of parental concern. Thus the nurses came to see that the way in which they perceived differences within a group would affect their skill in leadership, that if they could regard the young people from diverse backgrounds as being able to contribute to the broadening of one another's points of view, they could use their understanding of these differences constructively to help them cut through the economic and cultural barriers to mutual understanding.

Another factor that had confused and shocked some of the nurses was the degree of family distress revealed by some girls from "nice, middle-class homes." They had had no idea so much real trouble often lay hidden behind the overlay of middle-class financial comfort, education, and opportunity. In the followup sessions, they came to recognize that the kind of accepting group atmosphere they had provided the girls may have enabled some of them to open up freely about their feelings for the first time. Some of the nurses said they had become much more aware than they had previously been of the counseling needs of young persons from "average" families, as well as of those from families with more obvious problems. They realized, however, that they themselves were not equipped to deal with serious family problems and that the group discussions were not intended for this.

Many of the trainees also had difficulty in maintaining a balanced viewpoint, one not identified too closely with either the young people, their parents, or the school authorities. To help them with this aspect of leadership skill, the staff again emphasized the importance of encouraging the free interchange of differing points of view.

To broaden their perception of intrafamily relationships, the nurses were asked to identify the issues bothering parents of adolescents as they reviewed the records of parent groups led by trainees in earlier CSA programs. They were also given an opportunity to discuss ways of counseling parents individually, since in their regular jobs they worked with parents as well as with young people.

The staff's emphasis on the emotional implications of the issues adolescents are concerned with was not intended to overshadow the importance of the factual knowledge that nurses bring to their work with young people. However, some trainees had tended

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to go overboard for a time in exploring feelings and to neglect the presentation of factual knowledge about health needs. Restoring the balance proved to be a major supervisory task.

The followup seminar ended with consideration of ways to improve communication between the nurses and the other professional persons—teachers, guidance counselors, school administrators—who were also working with adolescents and parents within the school system. Some of the nurses had encountered some difficulties with school personnel who had failed to understand the purpose of the program.

Nevertheless, one of the most rewarding results of the program has been the positive impression it has made on the agencies and schools in which the trainees worked. Some of the nurses have since been asked to lead groups of unwed adolescent mothers. Others have been asked to use their learning and teaching materials acquired in the program in supervising the work of beginning school nurses. School guidance counselors, social workers, and administrators have met with the nurses to learn more about the goals of the group leadership program and have expressed great interest in helping promote further work in this area.

Some of the trainees were unable to lead new groups under supervision between April 22 and June 1, when the program officially ended. However, those nurses who did take on new groups moved ahead in interesting ways. Two led groups of educable retarded adolescent girls. In these groups the same issues came up as in the groups of normal girls, and in much the same way, but the nurse-leaders had to exert more authority to keep the girls' attention focused on the topics under discussion, had to be more directive in their leading questions, and had to reemphasize, in simple, concrete language, the major points that had been made in the discussion.

Some lessons

What was learned from this program that might be retained, or profitably be changed, in future programs?

First, it became clear that the success of such brief, intensive training necessitates careful selection of the nurses to be trained. Whether young and fresh out of nurses' training school, or older and experienced, the trainees should have a strong desire to participate in this type of program. Reluctant or overburdened nurses, not particularly interested in adolescents, or nurses satisfied to relate only to the physical needs of young people are not likely to make constructive use of the experience. Trainees should also have some previous knowledge of child development and family interaction, as so brief a period of training can serve only to refresh the nurse in her knowledge and to resensitize her to the complexities of daily family living from which the problems of young people stem.

Hindsight suggests that more specific interpretation of the purposes of this kind of issue-focused small group discussion program prior to the program's initiation should be afforded to other professional people in the same setting—in this instance, school social workers and school guidance counselors. Some overlap of function may be unavoidable, but if the nurses' colleagues from other professions understand that the nurses will be bringing a new dimension to their responsibilities for health education, they will be able to see the program's potential.

If mail supervision could be supplemented by more frequent personal consultations and some staff observation of the nurse's group leadership, the trainee's learning might proceed further. Plans are now under way to train some of the nurses from this demonstration program to supervise other trainees from their own area. This should make more direct supervision possible for any future program of this type in the Denver area.

The challenges to both the trainers and trainees in this project were to take a fresh approach to the issues young people are struggling with today, attempting to view them as the young people do themselves, and to develop methods of helping the young people cope with their problems more effectively. Their experience in the project revealed the nature of the issues young people are concerned about and the ability of school nurses to deal with them in a truly meaningful way.

[1] Cohen, Franklin; Rabinow, Mildred: Consultation process in training for mental health education: the use of correspondence and observation. Presented at the National Conference on Social Welfare, Atlantic City, N.J., May 1965.

a physician presents his views of . . .

the role of the NUTRITIONIST in an ADOLESCENT CLINIC

S. L. HAMMAR, M.D.

The use of an interdisciplinary approach can often be an effective method of handling some of the special problems that adolescent patients present. The University of Washington Adolescent Clinic is a medical clinic that has used such an interdisciplinary approach in providing diagnostic services and health supervision to teenagers. Because many of the problems encountered in this age group relate to nutrition, the nutritionist has been an important member of our clinic since its inception in 1959. In the ensuing time, we have had the opportunity to explore the many ways in which she can use her professional skill, not only to assist in the care and management of adolescent patients, but also to enhance our understanding of this age group.

It is difficult to define the role of the nutritionist in our clinic because her position is not static but, rather, one which is flexible and dynamic. She has been given sufficient latitude to create, define, and build her own unique role, drawing upon her previous training and experience. Thus she has been encouraged to use inventiveness and originality in approaching her responsibilities. Since the nutritionist is a member of a multidisciplinary team, she has to be able to communicate meaningfully with the other professional persons—representatives from the fields of medicine, social work, psychology, and public health nursing.

Perhaps the best way of describing the nutritionist's role in our clinic is to define the way in which she relates to the members of the other disciplines on the team.

Nutritionist and physician

When asked by the physician to participate in the evaluation and treatment of an adolescent patient, the nutritionist functions in four ways: (1) as an investigator; (2) as an advisor; (3) as a therapist; and (4) as an educator.

As an investigator: Customarily, the nutritionist in our clinic interviews the teenager without his parents, though at times she may need to see other family members to obtain adequate information. Her effort is to secure an accurate assessment of his eating habits and dietary intake.

Communicating effectively with a teenager involves an understanding of the normal behavior of adolescents, their manners and mode of talking, and their typical habits to determine whether or not the patient deviates significantly from his age group. It also requires the nutritionist to have an understanding of the cultural patterns in the patient's social milieu.

The physician is usually less interested in a detailed accounting of the patient's caloric and nutrient intake than he is in the nutritionist's own observations of the teenager. Therefore, the nutritionist's report

includes information on: how the boy or girl relates to her as an adult; his attitude toward food; whether there are family problems centering on food or mealtime; and his reliability and accuracy as an informant. She tries to evaluate whether or not the adolescent is maturing normally in his eating patterns and is beginning to assume some responsibility for his food selection and nutrition.

During the course of an interview, some adolescents bring up problems with the nutritionist that they may hesitate to discuss with their clinic physician. For example, girls with menstrual complaints or who are concerned about their sexual development may avoid bringing these subjects up with a male doctor, but feel free to talk about them to the nutritionist because she is a woman. The nutritionist can explore such problems sympathetically with the patient, making it clear that they will be brought to the attention of the physician.

As an advisor: The nutritionist recommends to the physician whatever changes, if any, are indicated in the dietary. In addition, she makes suggestions for instituting such changes. It is not enough for the nutritionist to tell the physician that a teenager's diet is low in iron or in calcium or ascorbic acid. To provide a useful consultation, she must consider some important questions: How does one get the adolescent to accept changes in his diet? What foods are most acceptable to him? What are his food likes and dislikes? How does one reinforce good eating habits in teenagers? What is the prognosis for change and do other members of the family need to be involved or counseled regarding his nutritional problems?

As a therapist: In treating adolescents with problems such as obesity or growth failure, the nutritionist is often called upon to assume the role of a therapist—to counsel and supervise the adolescent with a specific dietary regimen. In our clinic the physician and the nutritionist often see the patient on alternate visits, thus giving the patient more attention than either could give alone. If one is to work effectively with these patients, there must be close supervision and frequent contacts.

We have found that in many instances teenage girls with such problems as obesity may relate better to a woman. Working with an adolescent in relation to the diet often provides an entree for discussing many types of problems related to maturation and growing up. Our nutritionist, for example, in her counseling role often can help an obese girl develop her social skills and improve her hygiene and grooming. Being a woman, the nutritionist can serve as a good adult model for identification, particularly for the teenage girl who may not previously have had a healthy adult woman to emulate.

As an educator: The nutritionist helps to keep other members of the multidisciplinary team informed of current developments, new ideas, and recent studies in the field of nutrition. She can supplement a team consultation on almost any type of patient or medical problem with information or research data reported in the professional literature. This tends to bring the staff up to date, increase their interest, stimulate discussion, and often produce new and fruitful ideas that can be used in patient management.

Nutritionist and nurse

Although the nutritionist in our clinic accepts referrals only from the physician, who has ultimate responsibility for the care of the adolescent patient, she has ample opportunity to work closely with the staff members from other disciplines, especially the nurse and the social worker.

The nutritionist and the nurse can often reinforce each other's efforts in relation to grooming, hygiene, and dietary supervision. The nutritionist can support the nurse's attempts to improve a teenage girl's appearance by making it a point to compliment the girl upon her dress, her hair style, or her makeup, thus helping to bolster her ego and to create an awareness of how she affects others. The nurse, on her part, can review with the teenager the nutritionist's dietary instructions. In this way, she is frequently able to detect areas of misunderstanding and confusion that require additional clarification. Her followup contacts provide a means of determining how much nutritional information has been retained by the patient, and whether the patient has sufficient motivation to adhere to the prescribed dietary regimen.

At times, the nutritionist and the nurse find they can operate more efficiently and effectively through working with teenagers in groups. For example, the nutritionist and the nurse in our clinic have conducted a "self-improvement" group for obese girls. The purpose of such a group is to provide an accepting atmosphere and to create a situation in which the overweight girl can receive some gratification from interacting with members of her own age group, develop her social skills, and improve her self-image.

The nutritionist and the nurse, working together, provide the girls with dietary education, arrange social activities, enlist the aid of outside speakers, organize field trips, and set up volunteer work projects.

Nutritionist and social worker

In our adolescent clinic, the social worker has contact primarily with the parents of the teenage patients, initially to obtain background information on the family and later to provide short-term counseling, if indicated. The nutritionist and the social worker work together cooperatively in many ways. Often the nutritionist, through her contacts with the adolescent, is able to provide additional insight into the home environment and the intrafamily relationships. It is not unusual for her to uncover problems, once she has established a good relationship with the adolescent, that may not be apparent to the social worker or the physician.

For example, obese adolescents often complain that their parents tend to make it difficult for them to lose weight or to adhere to a diet. Parents of an obese teenager usually need help in recognizing their own contribution to their child's weight problem. Often, in subtle and unconscious ways, such parents tend to undermine the dietary program by nagging the adolescent or belittling his effort to lose weight. They may tempt him with readily available desserts and snacks. The parents of an obese teenage girl, for example, may insist that she be responsible for preparing the family's meals. By maintaining close communication with the nutritionist, the social worker becomes aware of such problems and can discuss them directly with the parents, helping them modify their behavior and attitudes toward the obese adolescent.

Types of problems encountered

The most common types of problems in which the nutritionist becomes involved in our adolescent clinic are the following:

Obesity: This is a prevalent and frustrating disease that characteristically involves a dependent, passive, adolescent girl, who usually has little motivation to lose weight. Obese boys, of course, are seen. Generally the nutritional evaluation involves two steps.

Step 1 is information collecting. The nutritionist assesses the patient's normal eating habits, and knowledge of calories and food values, and investigates critical areas that may contribute to the obesity problem, such as the family attitudes toward obesity, the availability of money to purchase appropriate foods, previous attempts at weight control, responsibility for meal preparation, family activities, and exercise patterns. This part of the workup, which may require several interviews with the adolescent, provides a baseline of data on the patient. Such information must be collected before modifications are made in the dietary, in order to determine subsequently whether or not progress has been made.

Step 2 is instructional. This involves providing the patient with a weight-reduction program. Such a program is planned after the nutritionist has conferred with the managing physician and a joint decision has been reached regarding the advisability of attempting weight reduction in the particular adolescent.

With some obese patients, the nutritional evaluation may not immediately, if ever, be followed by the treatment phase. Initially, a direct attack on the weight problem may be contraindicated. This is often the case if food and "overeating" have become a source of serious conflict or stress in the family and if the adolescent seems severely depressed. Thus, the nutritionist does not feel obligated to stress weight reduction nor to prescribe a diet for every obese patient referred to her. However, when an adolescent appears to be well motivated and when there are no contraindications for weight loss, the nutritionist becomes a consistent contact for instruction and support.

Growth failure: Many adolescents who come to our clinic are concerned about their physical growth, particularly the short statured, the physically weak, or the sexually delayed male. The nutritionist contributes a great deal to the therapeutic program for

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such patients, not only by helping them select the proper foods and by encouraging good eating habits, but also by treating them as responsible adults. Often parents and other adults tend to look upon the small adolescent as a child and to treat him as much younger than he is. When the nutritionist recognizes the boy's sensitivity about his short stature and treats him as an independent young adult, she helps to bolster his sagging ego. Wisely, she works with the adolescent boy alone and avoids direct involvement with his mother.

Mental retardation: About 20 percent of the referrals to our clinic are for mental retardation. The nutritionist has contributed much valuable information to our understanding of retarded adolescents by exploring their eating habits, their feeding skill, and the use of food in their families. We have been impressed with how often food, particularly high carbohydrate items such as candies, snacks, and desserts, is used as a reward or a bribe for good behavior. We have also found that parents tend to give their retarded child the kinds of food he likes best and are sometimes hesitant to introduce new items to his diet. As a result, the nutritional intake of retarded adolescents is often poor and lacking in important nutrients.

Because so many of the nutritional problems of retarded adolescents can be traced to the parents' tendency to infantilize them, the nutritionist concentrates on helping the parents encourage more independent behavior. She not only shows them how changes might be made in the adolescent's diet but, if the retarded adolescent is a girl, also encourages her participation in food preparation and other homemaking activities—areas of skill development that frequently have been neglected by mothers who underestimate the potential abilities of their retarded child.

Skin problems: Teenagers are very much concerned about their appearance. Acne, a source of much unhappiness, is a common problem which brings many adolescents to our clinic. The nutritionist helps reinforce the physician's therapeutic regimen through dietary instruction and encouragement and by helping them choose proper foods. She is especially careful to take a positive approach when dealing with these young people, emphasizing the foods that are permissible rather than only those that are forbidden.

Some principles

In summary, the experience of our adolescent clinic indicates that a nutritionist can make an important professional contribution to the successful functioning of an interdisciplinary team when—

1. She is inventive and resourceful in her consultations and in making nutritional recommendations, and is able to sell her ideas to other professionals, particularly the physician. (Many physicians have had little experience in working with nutritionists and tend to identify them with the hospital dietitian, who functions in quite a different capacity.)

2. She is not afraid to make observations on aspects of the adolescent's behavior other than those related directly to nutrition.

3. She does not feel bound by tradition and is willing to try new approaches or methods in dealing with teenage patients.

4. She asserts herself as an independent member of the team, yet, at the same time, is able to work cooperatively with members of other disciplines.

5. She recognizes her limitations and, if she feels she cannot work effectively or comfortably with certain types of patients or age groups, reveals this to the staff and seeks other ways in which she can contribute.

6. She periodically evaluates her accomplishments to find ways to expand the scope of her activities and to broaden her understanding of the needs and behavior of adolescents.

Functioning in this way, the nutritionist can make a unique and significant contribution to the total care of the adolescent patient.

moving EMOTIONALLY DISTURBED CHILDREN

from institution to foster family

REGINA V. FINE

"Are you having a good discussion?" queried a bright, impulse-ridden 9-year-old boy, poking his head in the doorway for about the sixth time during an emergency session the social worker was having with his foster mother. Abandoned by his natural parents before he could remember, David had, as he expressed it, "messed up" several foster homes and spent 3 years in an institution before being placed in one of our special foster family homes for emotionally disturbed children. For the first time in his troubled life he had begun to trust adults and tentatively think of putting down roots. Then once again he had exploded with antisocial behavior, causing a crisis in the foster home. He was anxiously awaiting the verdict. Was he to be rejected again?

David's erratic behavior is typical of what the Family and Child Services, a voluntary agency in Washington, D.C., faces in its daily struggle to maintain severely traumatized children with specially selected and trained foster parents. Periodically, these patient, forbearing people seem to reach the limit of their endurance and then the agency must immediately respond to their call for help, bolster their egos, and encourage their efforts, so that with renewed vigor they can return to the task of helping the children who need them.

In August 1963, Family and Child Services, with a small grant from a private trust fund, undertook the task of meeting a community need, that of developing special foster family homes to care for children with varying emotional disturbances and to contribute to their healthy growth and development. The program chiefly serves children who are ready to return to family living after being in a residential treatment center, but whose parents, due to their own unresolved problems, are not yet prepared to receive them or may never be able to do so. It also serves some children referred from psychiatric clinics as needing to get away from a damaging environment before their problems become so acute as to require their placement in a residential treatment center.

Thus far, we have placed 17 children with 13 foster families. Seven children have been in placement with us for 2 years or more, three for at least 1 year, and seven others for shorter periods. Our children have ranged in age from 5 to 13½ years at the time of placement. Eleven are boys and 6, girls; 6 Negro and 11 white. Their socioeconomic backgrounds range from lower income "culturally deprived" to upper middle class "culturally advantaged." Thirteen children have come to us from five different institutions—a large public institution for dependent and neglected children and four small, voluntary residential treatment centers for emotionally disturbed children. The others have not been in residential treatment and, we hope, will not need to be.

Initially, we had planned to place only one emotionally disturbed child in a family. However, we have experimented with multiple placements in instances where the foster parents gave promise of being able to manage more than one sick child. This arrangement offers the advantages of lessening the

Based on a paper presented at the 3d Annual Conference on "Foster Care for Emotionally Disturbed Children," Merrill-Palmer Institute of Human Development and Family Life, Detroit, Mich., Feb. 25–26, 1966.

sense of isolation for the new child being placed and stimulating the healthy development of the child already in the home. It also makes it possible for the social worker assigned to the program to concentrate on fewer homes while serving more children.

Preplacement planning

As we demonstrated our ability to secure the kinds of foster homes needed to meet the individual needs of disturbed children, we began to be asked by clinics and residential treatment centers to participate in multidiscipline staff conferences about children for whom foster family care was under consideration. Thus it has become possible to plan ahead for individual children, to look for a home, with a specific child in mind, to establish routines for exchange of information, and to work out more careful, satisfactory preplacement procedures. To avoid jurisdictional problems, our program has assumed responsibility for preplacement costs, such as payments to foster parents for weekend trial visits and transportation to and from the institution.

One day, we hope, movement of any child from one place to another, be it institution to foster home, own home to foster home, or changes in foster homes, will be done with as much careful planning as we in specialized programs are trying to manage today. A carefully prepared transition is, however, especially important for the child who is going back to the community from a treatment institution where he may have felt the only security he has known in his life. In our program, it often takes 3 or 4 months.

We had thought parents would be available to participate in preplacement planning, but none of our children have come from intact families. Most of them are extremely vulnerable to rejection, having experienced it many times in their short lives. Some have never known their natural parents and have only fragmented memories of early foster homes that failed, often for reasons obscure to them, leaving scars not easily healed. Some come from homes broken by the father's desertion or imprisonment in which the mother has had a succession of paramours. Some have inadequate, disturbed parents who flit in and out of the picture making elaborate promises that they never fulfill. Some have brothers or sisters who have been kept at home, thus adding to their intense feelings of rejection and low self esteem.

One 10-year-old girl "laid it on the line" during her first interview with me, as the person who would find her a family. She said, "I'm ugly. I'm bad. I'm no good. I set fires." Her self-appraisal was based on the many unhappy experiences she had had in foster family living. If I was going to look for parents for her, she reasoned, I had better know the worst!

Transitional therapy

Preparing the child for foster family placement stirs up old traumas which may have lain dormant during the child's years in an institution. It means encouraging the child to give up the tenacious fantasy that one day his mother (or father) will set up an ideal home for him. In this period, the child needs the opportunity to express his feelings of anxiety, ambivalence, and fears of the unknown, as well as to reevaluate the past and the present more realistically so that he can participate in planning for the future. This can be a most productive period therapeutically for the child, for he may reveal conflicts to the therapist that he had never revealed before.

We have learned that instead of waiting for the "old" therapist to taper off before the "new" one takes over, as is traditional in clinical practice, it is better to have the child begin to relate to the new therapist—the placement agency's caseworker—while he still clings to the therapist at the residential center. In this very difficult period of transition, the child can use more intensive exploration of his problems than can be managed in once-a-week contacts.

We have found that, at first, the child's conversations with the new therapist are limited to questions regarding the foster family, reports of weekend visits, complaints regarding restrictions, and the like. As the relationship with the new therapist deepens, some of the old doubts and worries, previously only aired with the residential therapist, are brought into our sessions and the roles of the two therapists seem to become fused into one. This eases the child's transference from one therapist to another and cuts down

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on separation anxiety. Of course there needs to be a close working relationship between the therapists, a mutual trust of each other's competence, self-awareness of feelings derived from vested interests, and a constant exchange of information as to what is going on in the therapy sessions, in the residential environment, and in the foster home.

Learning from failure

Anyone who undertakes to move a child from residential treatment to a foster home, even one especially selected to meet the anticipated needs of the disturbed youngster, is taking a calculated risk, though the decision is made out of the best clinical judgment that the patient is ready for the move. Therefore, he must be prepared for failure, as well as success, recognizing that as much can be learned from one as from the other that can later be put to use in the service of other children. As one of our 12-year-olds sagely announced after a year in successful placement, "Everybody makes mistakes sometimes, only you gotta learn from them so they don't go to waste."

One of our early placements was John, a teenage boy who had spent almost half his life in institutions. The middle child of 11 children in a deprived, disorganized family, he had been sent to a large public institution for dependent and neglected children at age 7, after his mother was admitted to a mental hospital. When he was only 8 years old, he had attempted suicide by hanging. After observation in a psychiatric ward, he was placed in a residential treatment center. At the time he was referred to us, John was an attractive youngster whom a recent spurt in growth had changed from a small boy dubbed "Peewee" to a "big boy" tolerantly accepted on the fringes of the older adolescent group. He expressed eagerness to leave the institution to try life with a family.

In accordance with our preplacement procedure, the prospective foster parents visited the treatment center with the social worker, were briefed by the staff on the boy's background, present condition, and areas of possible friction, and met John, who conducted them on a tour of the buildings and grounds. They invited him to spend the weekend with them, and there followed several weekend visits before placement was finally effected. Arrangements were made for John to continue his weekly sessions with the institution's therapist during the first month in his new home, and for this to taper off as the new therapist took over and established a relationship with him. The foster parents were prepared to be warm and accepting but at the same time to keep their distance, so as not to overwhelm him with their closeness.

All the built-in safeguards did not help. After one month John ran away—back to the residential treatment center. Why? Some unexpected and unfortunate events conspired to cause well-laid plans to go awry. One of John's buddies at the institution was found dead on the grounds. The staff and boys were upset, and the regular treatment appointments John was to have at the institution had to be canceled or deferred and John informed of the reason. Also, the close family relationships, the change from being an anonymous member of a group to suddenly having the spotlight turned on and being identified as an individual, had built up tremendous anxiety in this lad, who felt he had to keep a tight rein on his impulses to live up to his foster parents' expectations of him.

His first complaint to me during this period was: "Living in a family has more restrictions than being in an institution." Upon reflection, I had to agree with him. Parents feel responsible and like to keep track of a child's whereabouts. They show their interest by asking questions and including the foster child in their leisure-time activities. John had thought of family life as freedom to do as one pleased. Now he felt hemmed in by too much attention.

"Isn't it unusual for a child to reject the home?" the director of the treatment center asked me. I responded that John probably needed to reject the foster parents before they rejected him. But I was wrong. When I asked John about this at the center immediately after the runaway episode, he showed surprise and emphatically stated, "But they never would have rejected me." He had been quick to perceive that the strength of character and tenacity of purpose in these foster parents would have made them keep on trying to make the placement succeed. Therefore, the usual acting-out behavior would not have served to release him from what he regarded as an untenable situation; the only way out was to run. John could not tolerate the threat of close relationships and had to cling to the institution as his prime source of security.

What happens to the foster parents when the child in whom they have invested so much rejects them? Always a traumatic experience, such rejection can be especially shattering when this is the first child placed with them. John's foster parents were young, deeply religious people, who had had no children of their own. They did have a 7-year-old

adopted daughter and had looked forward to foster parenthood as a way of giving another child the same kind of devoted care that had nourished her.

The strong relationship that these people had established with the worker during the home study made it possible for them to use intensive casework support after John left. The worker shared their feelings of guilt, their sense of failure, the blow to self-pride. She reminded them that the placement had been a team effort based on the professional judgment of a multidiscipline treatment group who had known the boy for years. She pointed out the positive side of the experience—what had been learned about John that might be used to help him.

To express our confidence in the ability of this couple to be adequate foster parents for the right child, we immediately set about making plans to place another child with them, a younger boy, Joe, from a different treatment center. Joe presented an entirely different set of personality problems and really "put them through the wringer." But after 2 full years in their home he is exhibiting marked signs of healthy development.

Preplacement preparation

We have talked with all our children before placement about their prospective foster parents, the other children in the family, if any, the pets, the location of the home, and the like. We have answered their questions as fully as possible and relied on the preplacement weekend visits to round out what they needed to know. We have learned, however, that for some children, particularly those who have come from disintegrated homes, who have been in an overpopulated center for several years and from an early age, an educative process is necessary to prepare them for family living and for participating in the outside world. They need to be told not just about the good things to anticipate, but also about what will be expected of them. Such simple things as how to behave at the table and how to use knife and fork properly can be real stumbling blocks for an anxious child faced with making his way alone in a strange environment. The foster parents may understand his mistakes, but what will happen when he eats in the school lunchroom or at a birthday party? Once a child is singled out as different, becoming the butt of his peers' ridicule is almost inevitable, and children know this. One of our children invited out for Thanksgiving dinner ate only celery, the only thing he was sure he knew how.

In the family and the community, children develop defenses to cover their areas of vulnerability. But children who have never developed healthy defenses or whose defenses have broken down are encouraged when they get to a residential treatment center to talk about their traumatic experiences so that they can be helped to cope with their feelings. These children then need to be taught what most children learn quite early in a family setting: that there are some things that are personal and private and are not to be discussed outside the family circle. Otherwise they may naively respond to friendly questioning in such a way that neighbors become apprehensive and warn their children against becoming too friendly with them.

One newly placed 10-year-old boy, when taunted by other boys, tried to excuse his strange, sometimes infantile behavior with "But I've got problems." His feelings were hurt when they did not understand. However, he quickly learned not to suck his thumb in public and gave up hiding behind trees every time a group gathered. Perhaps he could have managed that sooner had he been fully aware that outside the institution odd behavior is not acceptable even on the basis of unresolved conflicts. The treatment center may have good clinical reasons for not interfering with symptoms, but if a child is to live in the community, he must be helped to know how.

Some children who have lived in an institution for a long time have become accustomed to having activities planned for them and have not developed inner resources for entertaining themselves. In the foster home, they are at a loss to know what to do with themselves "between times." Since many of these children have learning problems, reading is not an activity they turn to naturally. They also miss the stimulation of having other children around.

Early in placement, some of our children complained of not being allowed to watch their favorite television programs. Since the foster parents denied restricting them, we were puzzled. Then we learned that the institution they came from took responsibility for calling the children in when it was time to watch TV. How would foster parents know this? Also, what parent would feel a TV program was so important as to warrant interrupting a lively baseball game in which a child was happily participating? Going into a family from an institution means adapting to a whole new schedule of daily living.

As a child prepares to leave the institution for the foster home, he almost invariably develops separation anxiety. After several happy weekends, just as we

begin to feel he is apparently going to make the transition smoothly, he may suddenly refuse to go for his weekend visit. He may say he hates the foster family, list many complaints, and even react violently if attempts are made to force him to go. At the bottom of this behavior is the reawakened deep fear of separation from the familiar, often expressed with tears, "If I leave, I can't come back." At this time he needs to be assured that he no longer needs to be isolated from the community, that the residence's staff members will not forget him, and that at some point he can return to visit.

Maintenance in placement

Similarly, there comes a time when the "honeymoon period" with his foster family is over. The child seems terribly unhappy, rejects the foster parents, and says he is sorry he ever left the institution. It is important then to consider whether it is now time for a return visit to the residential center. The decision has to be made on an individual basis, depending on an understanding of the emotional factors in the child's depression.

We do know that children tend to build up fantasies that glorify the institution and their ties with its staff. Going back helps to bring the institution into better perspective. If properly timed and carefully planned, a return visit can be extremely beneficial for the child. He can be helped to face the fact that nothing ever remains the same. There are staff changes, old playmates have gone and new children have taken their place, the walls of his old room may even have a fresh coat of paint. Though he may be a little dismayed at first, the child usually gets the message that he must move on and continue to grow.

Our foster parents are especially recruited to work with emotionally disturbed children and are paid $150 per month for their services and the child's board, a rate higher than the usual rates for foster care. An intensive home study over a period of about 3 months includes interviews with each member of the family, together and separately, and explores their motivation for offering foster care, marital and family balance, sensitivity, ability to cope with anxiety and handle crises, and flexibility. Out of the first 32 couples who applied, only 2 met our qualifications.

Our foster parents are unusual people, with great interest in providing a suitable environment for troubled children, willing to invest of themselves, to take direction from the agency, and to participate as "team" members in working toward our goals. We have attempted to increase their knowledge of normal and deviant child behavior, to help them avoid problem situations, and to support and sustain them through the inevitable crises that arise. We see the foster parents and children in weekly individual and sometimes family sessions, either in our offices or at their homes. We have tried to do a careful job of "matching" children and foster parents through awareness of the vulnerable areas of each.

To maintain a disturbed child in placement, the caseworker must quickly establish a close relationship with the child, as well as the foster parents. Thus he can keep aware of the emotional climate in the home and sometimes nip a crisis in the bud.

For example, one of our foster mothers became pregnant for the first time after 12 years of marriage. She and her husband had adopted a little girl and also taken in two of our boys for foster care. One boy had been with them for more than a year and had progressed well. The other, recently placed, was still having difficulty finding his "sea legs." Shortly after we were advised of the mother's pregnancy and before the children had been told, the "new boy" confided that he had a "problem." The little girl had told him that "Mama had changed her mind and in 9 months she would send him back to the institution." He thought she had overheard this. Quickly, but diplomatically, the matter was discussed with the foster parents who, although they had never even considered giving up the children, had been emotionally preoccupied and oblivious of the effect this was having on three very perceptive and anxious children. The fact that there was a relationship between the caseworker and the most disturbed child helped prevent what might have become a critical situation.

The natural parents

The group of children we have placed so far have had parents who for various reasons were either completely out of contact with the child or unavailable for any casework services. Our attempts at forming some relationship with the few parents and one set of grandparents who have expressed interest in their children have been time consuming and fruitless as far as hope for effecting any real change in their attitudes or ability to provide a fairly stable home. The most we have accomplished is the establishment of some controls to limit the damaging effect distraught parents can have on their children and to prevent their interfering with therapeutic plans. In one

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case, we reluctantly had to release a severely disturbed child to a highly disturbed mother, although he had made remarkable progress in his foster home, because the mother created constant and violent disturbance in the foster home.

We can, however, report success in enabling another mother, first, to tolerate the controls necessary for preventing her unconsciously destructive influence on her child, and, second, to accept the kind of help she personally required but had never been able to admit was necessary.

Tom, a handsome 8-year-old boy, was referred to our program by a 5-day treatment center, because all attempts at therapeutic intervention were being thwarted by his weekends at home with his widowed mother. Confined to a wheelchair because of a leg amputation, she had been able to care for Tom as a baby, but as he grew older she was unable to impose the restrictions necessary to help an active, alert boy develop properly. She babied and overindulged him and encouraged a seductive relationship between them that kept the boy so overstimulated that he had little control over his impulses.

The mother denied having any problem with Tom until he became so completely unmanageable he kicked her leg and set fire to her mattress. Tom was then referred to a psychiatric clinic, but when it became apparent that psychotherapy could not help him so long as he remained with his mother, he was placed in a residential treatment center.

Though mother and child had been known to our agency since Tom was about 3, the mother had never been able to admit her need for assistance other than with practical matters. By viewing the problem as the child's only, she avoided personal involvement in a therapeutic relationship. However, when she was forced to face the need for permitting her son to be placed in a "full-time foster home," she was able to consider her own need for help.

The big problem for Tom's mother was the fact that she had so few sources of emotional satisfaction. As an attractive, intelligent girl of 19, she had been a registered nurse working in a hospital's nursery for newborns. Then she had lost a leg in an accident and so her hope of professional achievement. Years of rehabilitative efforts had made her completely self-dependent in regard to her own personal needs and able to manage her household efficiently without outside help. But Tom had given purpose and direction to her life; with him away, the days were long and empty. One day as she discussed her frustration with her caseworker, she referred to how useful she had felt when Tom was an infant and she had been able to meet all his needs. She felt she could do the same for other babies. She had heard that our agency was in urgent need of foster mothers for infants awaiting adoption. Would we consider her?

After much consultation between the agency's departments, we came to an affirmative decision. A 3-week-old, premature baby was placed with her, and in the ensuing 8 months we were able to observe what expert, tender loving care can do for an infant who has had a poor start in life.

What has this done for Tom's mother and for Tom? As the mother began to feel productive, her feeling of self-worth increased, depression came less frequently and soon disappeared altogether, her attempts to sabotage our work with Tom became rare, her hostile attitude toward his foster parents gradually changed, and the change was conveyed to Tom so that he felt freer to become closer to them. She became actively able to support our treatment goals and to allow Tom to separate from her and to take steps toward maturation. She gave clear evidence that she had emancipated Tom in her Christmas cards, which previously had been signed "Tom and Mary Jones," as though they were husband and wife, but were now signed "Mary Jones and Tom." She also began to spend money on herself instead of showering everything on Tom as she used to do.

Tom has had some difficulty in adjusting to his mother's involvement with another child, but we have been able to help him work out some of his feelings in therapy sessions. His hyperactivity has markedly decreased. His attention span has increased so that he is able to finish his work and achieve at grade level in school. His aggressive attacks on younger children, which threatened to result in expulsion from school last year, seem to be ended.

In conclusion

In this paper I have attempted to delineate some of the most frequent problems encountered in helping an emotionally disturbed child move from the protected environment of an institution to the world outside and have offered some suggestions as to how these might be handled. I shall end with a plea for creative exploration of new ways of helping such children. Within even a small, somewhat traditional type of foster-care program, there is much room for flexibility and experimentation, if one is willing to invest the time and effort necessary and is brave enough to take a calculated risk.

keeping EMOTIONALLY DISTURBED foster CHILDREN in school

WALTER J. AMBINDER ● LOUIS H. FALIK

A basic assumption of foster-home placement is that the child being placed has some ability to live in and profit from a family environment and to maintain satisfactory relationships with the community of which the foster family is a part. The foster child's inability to get along outside the home—in the neighborhood or in the school—is often a major reason for the breakdown of the placement. Foster-care caseworkers have concentrated for the most part on supporting the home because their caseloads are so large they do not have time to guide untrained foster parents in working with such agencies as the school. Other than recognizing that the foster child often has difficulty in school, they are unable to pay sufficient attention to problems of adjustment outside the foster home. They are often in the uncomfortable position of sensing the potential stress that could destroy a good home placement without having the resources to prevent a crisis.

In short, although we know that a child's failure to adjust to school can overtax even the most stable placement and the most skillful foster parents, the methodology of effective intervention is uncertain. Because of this uncertainty, the work of school and agency to help a disturbed child is often difficult—yet it can know some success. The work of the Detroit Foster Homes Project with one boy, whose story this article will recount, is a case in point.

The staff of the 5-year-old Detroit Foster Homes Project realized the need to carefully evaluate the adjustment of foster children to school from the many case histories of emotionally disturbed children they studied before selecting the 14 boys with which they are now working. Sponsored by the Merrill-Palmer Institute of Human Development and Family Life with a grant from the National Institute of Mental Health (5R11–MH–01551–04), the project is demonstrating that children who have lived in many foster homes, who have been subjected to marked family disorganization, and whose conduct reflects emotional disturbance, can be placed and kept in highly reinforced foster homes.

For most children, school is a difficult lesson in reality testing, for in school they must prove their worth on their own. The foster child must react to the cognitive and social demands of the school without the love, security, and support most children get from their homes. His experience with many breakdowns in home environment can bring emotional instability and feelings of rejection and worthlessness. The case histories of the children selected for the project, all of whom had failed in several home placements, include many examples of difficulties in school, both academic and social.

These considerations have made us focus our attention on the adjustment of the foster child to school as a major aspect of his adjustment to life. In our school activities we follow two methods, one based on service, the other on research. The service method centers on school adjustment and the specific needs of the child, to provide effective supports for his day-to-day functioning. It includes contact with the school, clarification of the role of the foster parents in relation to those of school officials, direct

service to classroom teachers, and supplementary diagnosis and tutoring.[1] The research method involves the gathering of data on the adjustment of the child to school and includes basic data on which to determine the effectiveness of the project's efforts.

Our school intervention methods have meaning for child welfare practice everywhere, we believe. The most obvious meaning is that children who are as emotionally disturbed as those we work with cannot be kept in school, much less in foster homes, without special attention. It is our experience that many of the children who fail in a placement might have succeeded if attention had been given to their adjustment to school. Foster-care agencies must continue to seek effective ways of working with the school. Sometimes, this only means having a staff member who knows what causes concern to teachers, understands the social structure of the school, and has the ability to bring about change.

It is also our experience that if the agency can work effectively with the school, the child's prospect for a successful adjustment to the foster-home placement will be greatly improved. Most foster parents need the satisfaction of having the foster child succeed in school; if they are denied this gratification or are subjected to pressure from the school, they may reject the child. Several of our caseworkers have felt that the project's efforts to keep the child in school were the cohesive force that held the placement together.

At the time we placed the 14 boys the project has worked with in foster homes, we expected school adjustment to be difficult for them. Eight had already failed one or more grades. Although they were older than their classmates, all were at least 1 year below their grades in reading; four were 2 years below; and several were classed as nonreaders. On the basis of individual intelligence tests, none could be called mentally retarded, although the school considered several as retarded because of their poor performance on school paper-and-pencil intelligence tests and in class. In general, their cognitive functioning was similar to that usually associated with cultural deprivation, and it frequently suggested emotional problems. Nearly all had histories of poor social adjustment in school, exemplified by conduct ranging from fighting and destructive behavior to severe withdrawal, lack of participation, and extreme immaturity.

The case of Harold

The history of one of our boys, Harold, which follows, illustrates the extent and complexity of the project's involvement with the school and describes the evolution of our plan for intervention. His case was chosen because it highlights many of the critical issues we face, and it can serve as a basis for discussion of the general problems and prospects.

Harold is perhaps the most disturbed child we have had in placement. He is a small Negro boy who has never had a home of his own. His mother was unmarried when he was born, and all his relations have rejected him. He has lived in several foster homes. About a year before being taken into the project, he was removed from a foster home in which he had lived for 5 years because the foster-care agency found that the home had become inadequate. He had great difficulty in adjusting to the new home, and his conduct was characterized by temper tantrums, aggression toward other children, and disorganized and uncontrolled behavior. He was highly distrustful of people and unable to tolerate close personal relationships. So uncontrollable was his behavior that, in a short time, at the age of 7, he was admitted to an inpatient psychiatric hospital for study and treatment; 4 months later the project placed him in a new foster home.

After Harold had spent several comfortable days in his new home, we entered him in public school. The project caseworker went with Harold and his foster mother to the school and held a conference with the two teachers who were to have him for most of the school day. She told the teachers that Harold had been in psychiatric treatment and that his doctors felt that he could now function in a normal setting, gave them some facts about his academic and social deficiencies, and suggested ways of handling him. The principal was not included in the conference. Both teachers seemed sympathetic and understanding, and Harold was accepted on the first

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day with apparent smoothness. The day after, however, the principal called the project caseworker to say that Harold's teachers were unable to control him. He was surprised to learn Harold's history and was defensive about having to cope with such a child "without warning." Because he had not attended the conference, he felt unable to intervene effectively.

The effect of Harold's behavior on the teachers pointed up to us that merely sharing information and offering help were not sufficient. The teachers had "not heard" what the caseworker said.

The first days at school were overwhelming for Harold. At first, his behavior was confused; later it became disorganized, aggressive, and uncontrollable. When he slapped a teacher, two project staff members had to take him away. The principal felt that the school could not keep him unless he showed immediate and major changes in behavior. He had been in school only 3 days.

What modifications in Harold's behavior were possible, we asked ourselves. Apparently, the school had not been adequately prepared for his kind of behavior, and we had overestimated his ability to cope with the routine of the school day. Having come from a hospital's protective environment, where lessons were brief and the classroom confined, possibly the longer school day, the physical complexity of the school building, and the personal relationships the school imposed had overwhelmed him. With this in mind, we thought it important to determine how much information the school could effectively use and what kinds of supports we should offer. Consequently, we transferred him to another school near his home after we had conferred several times with the principal over Harold's history and school adjustment problems as part of a formal plan for his attendance. The principal agreed to place Harold with a teacher especially good with difficult boys, and to let Harold attend half-day sessions only.

The teacher was indeed skillful in handling him. Not threatened by his aggressive outbursts, she allowed him a good deal of physical freedom and continually assured him that she liked him and that he belonged in her room. She soon understood the conditions which set off his aggression and how to avoid them. The amount and intensity of his disturbed behavior began to subside. He was still difficult to handle, but he seemed to have reached a level of adjustment which both he and his teacher could tolerate. Toward the end of the semester Harold's stay in school was extended to a full day.

At the end of the semester, because of Harold's great academic deficiency and the special relationship between him and his teacher, the teacher felt she should keep him for another semester. We agreed. After the summer vacation, Harold returned to her class and continued to improve. He seemed to make friends, to work with others in the classroom, and to be almost able to conform to rules.

We had many questions, nevertheless, regarding the permanency of these changes. The sheltered relationship with the teacher and the other supports the program provided could not be maintained indefinitely. At the end of Harold's second semester with her, the teacher suggested that because of his age and size he should be moved on. The change, of course, brought a new teacher and a new environment. Because the project staff felt that Harold's adjustment was still far from adequate, we arranged for his old teacher to work with him as a tutor to provide a continual relationship through the next semester's changes. This plan was critically timed, as the new semester brought great stress to Harold.

The first new teacher we placed him with decided after 2 weeks that she could not control him. We then placed him with a teacher who, though highly experienced and competent, was rigid, aloof, and unwilling to admit that Harold had special problems. Nevertheless, he seemed to make an adequate adjustment and responded positively to increased controls.

Problems in the school

Harold's maintaining ties with the former teacher while working with the new one strained the social order of the school. The two teachers were soon competing with one another. The principal knew of their struggle but did not think he should intervene because he considered both teachers as competent, articulate, and strongly committed to making progress with the boy.

Although Harold was apparently responding positively to the increased controls of the new classroom, his reactions suggested emotional strain. Acting out became less pronounced, but he showed tension in other ways. He fainted in class and began to truant and to disappear within the school building. His aggressive outbursts were severe. In our judgment, the situation was becoming too difficult for him and our resources for keeping him in that school were being dissipated rapidly. We had to consider another change of schools.

All this time, the project had kept in touch with

the principal of the first school in which Harold was placed, who was following the case with interest. He now felt that he could provide a class with more flexibility and support than the second school and that there would be more possibility than before of bringing special help to the school and of involving the school and the project more closely. He assured us that he could place Harold with an especially skillful teacher, an assurance the second school could no longer give.

At the project, we had come to believe that the principle of stability in school placement was, in some instances, secondary to getting a child off a "hot seat." Although the second school was committed to succeed with Harold, it appeared to us that the attitude of its staff was frozen and its emotional climate was such that the teachers would have difficulty in seeing changes in Harold. There were arguments against changing schools, of course, such as the effect of frequent school changes on a foster child, the feeling of failure a change might bring to Harold, and the advantage of familiarity that three consecutive semesters in one school building had brought him.

We made the change, however, but the trend toward deterioration continued in spite of many contacts with specialists, flexible and sympathetic administrators and teachers, and attempts to structure his experience. Harold's aggressive and disorderly behavior increased in intensity and frequency. It became clear to us that a public school probably could not help a child with his needs.

At this point, we questioned Harold's suitability for foster-home placement and considered sending him into residential care. As a last move, however, we placed him in a private school with small classes and special programs for disturbed children. At first, Harold's behavior did not change. He could only attend school an hour a day.

A fortunate observation by the caseworker, however, brought a change for the better. She noticed that Harold's foster mother had a remarkably calming effect on Harold. At our request, the mother came to class with Harold and remained in the room while he was there. After several weeks, when he seemed better, she did not come to the classroom but remained in the building with Harold's knowledge. A little later, when he seemed even better, she remained at home on call, also with Harold's knowledge. As the semester passed, Harold's periods of control gradually lengthened, and we could slowly withdraw the massive support we had been giving him. He was able to concentrate on schoolwork for brief periods, began to show signs of learning, could attend school for a full day and ride the bus back and forth.

Recently we added an academic tutor, and some progress is being made on lessening his great academic deficiency. Although he still has behavioral difficulties and is far from ready for public school, the staffs of both the private school and the project believe he has made marked progress.

Working with the school

Harold's case, as we have said, highlights several basic issues in dealing with the school in behalf of emotionally disturbed foster children.

The most obvious issue is the necessity for shaping the school experience to fit the child's behavioral needs and capacities. With Harold, this went beyond what the public school or even the private school could spontaneously offer. Yet much was done within the public school. Our experience with Harold brought up questions regarding the timing of initial contacts, the extent of involvement of the foster parents, the role of the caseworker with the child and parents, and the role of the referring agency.

The problem of offering the school information about behavior that could be expected was crucial in the case of Harold, as with most emotionally disturbed children. An agency cannot assume that information relayed once is heard and understood completely. Rather, it should give information like a clinician—a little at a time as the client reacts. An estimate of the school's ability to benefit from a consultative relationship must be made and the operational usefulness of the consultation determined. To the degree that caseworkers can describe the child's functioning in terms meaningful to educators and outline problems and behavior the teacher is likely to face, preparation and flexibility will be easier.

Although it is important to provide continuity and individual help for the child, in Harold's case, because of his great emotional disability, our help created strain that hampered the school's ability to deal flexibly with his behavior.

The role of the tutor needs to be emphasized, whether he is a member of the school's staff (as in Harold's case) or a teacher from outside. The tutor's knowledge of the educational and emotional needs of the foster child, his ability to deal with the "building atmosphere" of a school, and his ability to explain the child's problems to the teachers keep understanding flowing between the school and the agency. His work also helps keep the agency abreast of planning

and aware of problems, even before they come into the open. With Harold, as with all other emotionally disturbed children, day-to-day life in school is tenuous. It is important to keep the channels of communication open, even against obvious resistance, to prevent a crisis or to lessen its force.

Another aspect of Harold's case, also present in the experience of most of our foster children, deserves attention. During the time Harold's school behavior was so turbulent, the project tried to stabilize and solidify the foster-home placement. The foster child has to make adjustments on several fronts at once, and sometimes demands for academic and social progress in school must be delayed until the child can establish a foundation of trust and security at home.

Casework intervention with Harold was designed to support him in his school attendance by meeting with him to talk about his problems, helping him develop other behavior patterns, and so on. At the same time, the caseworker worked with parents to interpret to them what was happening in school and to deal with the crises of daily living—to help Harold become acclimated to his foster home and to help his foster parents become used to his behavior and develop comfortable methods of coping with it.

Because many foster parents, lacking experience with the school, approach teachers and administrators with anxiety, the caseworker must often help foster parents understand the child's school problems. Conversely, the agency often does not know what strength the parents have for helping a child adjust to school. Harold's caseworker felt that if his foster mother had been more actively involved long before she was, Harold might have made greater advancement and have had fewer setbacks. An agency, therefore, must weigh the foster parents' desire for involvement with the school, their familiarity with the school, and the nature of the child's expected behavior to determine the kind and extent of foster parent involvement.

Some conclusions

The course of our involvement with school officials and the educational problems of the project foster children necessitate continual evaluation and planning. We are constantly retracing our steps and having to rise to crises. Although there are few guidelines for effective intervention in a child's school experience, we have been guided by several considerations: first, the need to insure the foster-home placement by insuring the child's school adjustment; second, the need to gather data concerning the problems and difficulties emotionally disturbed children meet in school and to determine what methods could be developed that would make adjustment easiest. These general considerations were evolved into specific issues by our advance planning and by the problems of keeping 14 foster children in school.

Harold's case material highlights these considerations and a few of the specific issues. We have not presented hard data because we wanted to emphasize the character of our involvement and of the personal interaction between agency and school. The problems arising from Harold's school attendance—such as his failure to learn to read at grade level and his fighting in class—have brought into focus the fact that such problems, how they are handled, and the effect they have on the foster child, the foster family, and the school can and often do influence the whole foster-home placement.

From our work with the schools, we have evolved several methods of working toward school adjustment. We have found that it is often useful to start contacts with administrators, rather than with teachers, before the child enters school to set the stage for contacts with teachers, to provide insight into the amount of cooperation available, and to keep channels open should "system-level" changes be considered. After conferences with the child's prospective principal and teachers, careful decisions concerning the sharing of information, further action, and the like must be made. We have found also that the importance of describing the child in school-related, operational terms and gaging the level of interpretation needed about his problems cannot be overemphasized.

From the standpoint of child management, we have found it essential to involve the foster parents as fully as possible in the child's school environment. In addition, the caseworker must often work closely with the foster parents around school problems.

We have also found it important to determine the kinds of special help the child can make use of and to plan with the child, the foster parents, and the school to provide such help. Occasionally, such planning will become the source of some conflict within the school "life space" of the child, but as the case material suggests, this can and must be worked out. The indirect benefits of such supports can be critical and can occasionally serve to sustain all participants through a crisis.

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[1] Shiefman, Emma: A schoolteacher in a child welfare agency. *Children*, May–June 1966.

how to alleviate the first-year shock of . . .

teaching EMOTIONALLY DISTURBED CHILDREN

SHIRLEY COHEN

Among the results of the Elementary and Secondary Education Act of 1965, with its encouragement of innovations to bring educational opportunities to "educationally deprived children," [1] is a widespread interest in establishing special classes for emotionally disturbed children. In some States this interest has been augmented by State legislation, as in New York State where the establishment of such classes is now mandatory. Though under a 1963 act [2] some Federal money has been made available to States for training teachers to conduct such classes, a great many schoolteachers with little or no special training will undoubtedly find themselves faced with classes for disturbed children in the near future.

While thousands of books, pamphlets, manuals, and articles are aimed at guiding the new teacher of a regular class, few shed light on the difficult task facing the experienced teacher who is working with a class of emotionally disturbed children for the first time. Therefore, it seems appropriate to describe some principles for approaching this task. Those that follow are derived from my own experience in just such a situation and from my subsequent work supervising other teachers in their first year of teaching classes for emotionally disturbed children.

The first year with emotionally disturbed children is often a year of crisis for the teacher—a year in which a teacher's beliefs, premises, values, and expectations are shaken. The approaches the teacher has come to have faith in do not bring the expected results, and the usually reliable methods for making things work better—more preparation and planning—prove not so reliable.

Whether a teacher's relationship to her class, her skill as a teacher, and her maturity as a person grow or wither depend on how she responds to the crisis of finding her "reliable" methods no longer working. She can respond to the shock of this new experience either by becoming more distant and more rigid, or by opening herself up to a kind of "culture" and a way of communication that are new to her, painful as this may be. Some persons who turn out to be the best teachers of classes for emotionally disturbed children have the most difficult time the first year. They are, so to speak, "shook up" the most, but the experience makes them more receptive to new ways of looking at events, new understanding, and new approaches. Take, for example, the following incident.

One day a teacher in her first month of working with a special class of emotionally disturbed children put on a record by the Beatles, got out some colored chalk, and encouraged the children to draw on the chalkboard to the music. Having taught for several years in regular classes, this teacher had a rationale for what she was doing. She felt that most of these disturbed children were too inhibited and needed more opportunities for free and creative activities. She had used this kind of activity successfully with classes of young children before.

For the first 10 minutes the result was beautiful. The children were interested and involved. They were communicating with one another and working cooperatively. The chalkboard was brilliant with color and design. But then the quality and tenor of the experience began to change. The children became wilder, less creative, and more destructive. The beauty of the cooperative production disappeared under a barrage of uncontrolled actions. The floor and the children themselves were covered with colored chalk. Some of the children became highly anxious.

Based on a paper presented at the First Conference of New York State Educators of the Emotionally Disturbed held in Hawthorne, N.Y., May 1966.

When I described this incident to a group of teachers of disturbed children, each one was quick to point out the teacher's obvious errors: she had used the wrong music, at the wrong time of day, without having established clear aims and limits. These criticisms had some validity.

Yet the experience turned out to be a good one for most of the children. The next day I watched the teacher talk to the children about what had happened, and it was obvious from their faces and their voices that something good was happening to them. For the first time in the lives of many of them a disaster in which they had participated was not being blamed on them. The adult did not turn against them; on the contrary, she was taking a share of the blame for what had happened. She said to them: "I didn't plan that very well, did I? Next time we'll have to plan more carefully."

This woman will most likely turn out to be an excellent teacher for disturbed children.

Some principles

The following are the principles that, I believe, if followed, could alleviate the shock of the first year with such children if understood by the teacher.

1. ***The teacher will do much better if she understands that what disturbed children need is someone who can be stable and orderly in the midst of their disorder.***

When I first considered teaching seriously disturbed children, I was advised against it by another teacher on the grounds that such children need a teacher who can regress with them. Time and experience have led me to a different viewpoint. What these children need is not someone who can regress with them, but someone who can live with, accept, understand, and see the need for their regressions, without becoming threatened or disrupted by them herself. The teacher who is cut off from her own feelings may not be able to understand and communicate with such children, but the teacher who is herself chaotic will not be able to serve as a model of health and strength for emotionally ill children.

On the physical level, for example, the idea that the teacher, rather than the children, has to be orderly means that for a long time the teacher may have to be the one who takes major responsibility for "setting up" and "cleaning up." Cleaning up is often a center of conflict between teachers and disturbed children. Here teachers fall back upon the old expectation that if children are properly warned of the approach of clean-up time they will or should clean up. If these children could get ready and clean up when, and simply because, the teacher told them to, they would probably not be in a special class. Being willing to clean up implies a set of attitudes and a degree of strength that do not exist, or exist only in rudimentary form, in many disturbed children.

2. ***The teacher of disturbed children will do much better if she comes to expect the unexpected.***

The teacher who is working with disturbed children for the first time, in a sense, is moving into a new "culture"—the language is different, the way of perceiving the environment is different, and the rules are different. It takes time to understand how the class differs from a group of normal children as well as to understand the idiosyncratic ways each child has of perceiving and relating to the world. Of course, it takes more than just time to understand disturbed children. Training and sensitivity are crucial. And some severely disturbed children will leave even the best teacher puzzled.

3. ***The teacher will do better if she expects and accepts little progress in some of the children for the first few months.***

It takes many disturbed children months before they are willing to conclude that the teacher is really for them, that they can really trust her, that she will not turn against them when the going gets rough. Until they reach this point, they may not be able to really get to the learning task that is the purpose of their being at school.[3] They may not be willing or able to expose what they do not know or what they want to know. They may not be able to accept the position of one who knows less in relation to the teacher as one who knows more.

The teacher will also do better if she learns to

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recognize other kinds of growth besides academic achievement. If a child who was a habitual truant now comes to school regularly, growth has taken place. If a child who in the past rarely finished anything, or immediately destroyed anything he did finish, is now able to accept some of his work and allow the results to exist, growth has taken place. If a child who used to respond to teaching efforts with braggadocio is now willing to expose what he does not know or cannot do and to ask for help, growth has taken place.

Time takes on a different meaning when one works with disturbed children. Something that a regular class may adapt to immediately may take a class of disturbed children weeks to accept. Here is where just the right amount of "flexibility" in the teacher counts. Some teachers rigidly cling to practices carried over from regular classes in spite of overwhelming evidence that these practices are not appropriate for the disturbed children now in their charge. On the other hand, some teachers, finding that nothing they try works immediately, shift about so much that the children cannot tell what is expected of them or what to expect.

4. The teacher will do better if she learns to attend to and understand nonverbal communication, her own as well as the children's.

Only a small fraction of what disturbed children feel or think is communicated through words.[4] The teacher has to learn to read gestures, facial expressions, body movements, and actions. Doing so will help her not only to understand the children but also to anticipate their reactions. Anticipation is essential in working with disturbed children. The teacher also has to become sensitive to her own nonverbal messages because most disturbed children learn to "read" them very well.[5]

In the following two examples, the teacher failed because of insensitivity to what the child was asking and how she was answering him.

Robert was a seriously disturbed boy who had been discharged from regular class in the first grade and was now in a special class. One day early in the term he came up to the teacher, removed a bandage from his right hand, and told her that his hand hurt. The teacher looked at the hand and replied: "That cut looks almost healed to me. Besides, the nurse isn't in today, and there's really nothing I can do for it." Then she turned back to her desk. Within 5 minutes Robert had attacked three children and disrupted the entire class.

This teacher had answered Robert's words in a rational manner, but in response to his message—"I need some support; I need to know that you care about how I feel"—her response, unfortunately, was negative.

Billy, another very disturbed child, had just returned to school, after having been excluded for 2 years in which he received intensive therapy and home instruction. The teacher was going around the room asking each pupil his name. When she came to Billy, he announced himself as Martin Luther King. The teacher became very angry and accused the boy of insolence and disrespect.[6]

This teacher felt threatened, and in defending herself forgot about the child. She might better have said: "Martin Luther King is a good person to want to be like," or "Martin Luther King is a man of peace, so I expect you to contribute to the peace in this classroom."

Thus she would have been telling Billy and the rest of the class that she was not being taken in, but that she recognized that he may have felt like nothing and nobody that day; that his response was a defense against his own feelings; and that she was not going to try to rip it away.

Awareness of nonverbal communication is also important for achieving *congruence* between words and actions and between methods and aims, an aspect of teacher consistency not often enough recognized.

5. The teacher will do better if she reexamines everything she does in the classroom in the light of the questions: Is this really worthwhile? Is it really a good way to achieve what I intend?

Probably most teachers who go about such a reexamination seriously will find that much of what they have been doing does not pass this test. Recently I watched a teacher who had had the same class of disturbed children for almost 2 years spend a half-hour on the attendance, the calendar, the weather, the daily "story," the patriotic song, and the seasonal poem, all standard procedures in the primary grades of many schools. During the process the children became more and more restless, bored, and cut off from the teacher. Afterward I asked the teacher what she expected to achieve by "doing the weather" every morning. She replied that she "did the weather" (with the pictures of a cloud, an umbrella, the sun, and a snowman) to make the children aware of the weather and of weather changes.

Why had this teacher not considered that if, after nearly 2 years, this daily procedure had not achieved the goal of making children aware of weather changes, either it was an inappropriate method or her goal was inappropriate? If the goal had been achieved, why was she "beating a dead horse"? The

elimination of such wasteful procedures will help eliminate some of the restlessness or apathy so often exhibited by disturbed children at school.

The teacher also needs to reexamine every aspect of classroom management, including selection and arrangement of furniture, use of bulletin boards, selection and storage of supplies, arrangement of activity centers. Which materials are kept in closed closets and which are left on open shelves? Where should the child who runs away be seated? Are "current events" only what one reads about in the newspaper, or do stories about events current in the lives of the children themselves also belong in this category and rate space on the bulletin board? Such questions are important in relation not only to classroom management but also to communicating the philosophy of this class to the children.[7]

Seeing individual needs

The crux of what a new teacher has to learn is to see not only the goals which she wants children to reach, but also how well all the parts of a child's personality—attitudes, controls, and areas of strength and skill—must be functioning before these goals can be reached. She has to learn how to help malfunctioning children negotiate the quarter steps toward these goals, small achievements which most other children do not need to work at consciously.

For this type of planning, preparation of the standard type—based on curriculum guides, reference books, charts, and the like—is not enough. Hand in hand with it must go another kind of planning, based on knowledge about disturbed children in general and about each specific child in the class. This kind of planning cannot be done by the teacher alone. It requires the insight of persons well versed in the recent developments in psychology, neurology, sociology, psychiatry, and education; in other words, a team of persons from different professional disciplines working together.

Such planning is concerned not only with the standard questions about reading, writing, and arithmetic, but also with such questions as: When should the teacher keep out of something and when should she move in to confront the child with reality? What should she do about such group reactions as scapegoating? How much protection can she give a child without fostering unhealthy dependency? How can she tell when she is becoming overinvolved with a child and perhaps repeating an unhealthy parental pattern? How can she know when withdrawal signifies a marshalling of resources when it is serving no healthy purpose? What avenues of expression are to be made available to a particular child and what ones are to be avoided? How much weight is to be given to general school standards and expectations in defining special class activities and procedures? How can a child be prepared for return to a regular class?

Behind the labels "emotionally disturbed children" or "maladjusted children" are children having widely varying symptoms, degrees of pathology, and etiology of pathology. Some are aggressive, destructive, and delinquent; others are self-destructive, picking at their skin, banging their heads, biting their hands. Some are far behind in academic achievement; others are academically advanced. Some are constantly fearful; others show an abnormal lack of fear. Some are hyperactive and impulsive; others are lethargic and withdrawn. Some are caught up in complex fantasies; others are extremely concrete. Some are only mildly troubled; others, deeply so. Some are responding to the stress of acute situations in their lives; others have shown abnormal behavior since birth and are extremely disoriented.

Thus, in working with a class of disturbed children, the teacher cannot address herself to "the group." She must study, plan for, and relate to each child as an individual. It is here that she needs the help of the mental health specialists—psychiatrists, psychologists, social workers—who work in or with the school.

Teams, of course, will vary according to the type of personnel available. For example, in one school I know of a team, which consists of three teachers assigned to special classes, a psychiatrist, and a school guidance counselor, meets regularly once a week. Additional school or outside agency personnel, including social workers and psychologists, are asked to attend the team conferences when their special skills are particularly needed. The guidance counselor also meets separately with each teacher weekly.

In this school, a few weeks after the beginning of a term, a team meeting was focused on planning for a 7-year-old boy, David. Even among his peers in the special class David's behavior appeared bizarre. He never said a word to anybody about anything going on in the class, but occasionally he would come out with a phrase which seemed to make little or no sense. Anxious about how to deal with him, his teacher described his behavior to the others at the conference. The psychiatrist who had been seeing David individually told about some of the factors in David's background which seemed to have a bearing on his behavior, and then the team members considered together how to help David in the classroom.

Since childhood David had been cared for by his father, a seriously disturbed person who regarded himself as a poet. He

only attended to David when the boy said something "poetic"—something unrelated to everyday needs and expressions. Then, the father, who himself often spoke "poetically," wrote David's words down and showed him much affection. The father was now no longer in the home and David's mother had become very much worried about David's verbal behavior.

The psychiatrist explained that David's strange way of speaking was probably a normal reaction to his past environment. The team decided that the teacher should relate to the boy in the following ways: translate his bizarre statements into everyday language whenever possible; talk to him as much as possible in simple words about concrete, pleasurable activities—eating, blockbuilding, ballplaying, woodworking.

Feeling more confident, the teacher was able to carry out this plan. She and the guidance counselor continued to discuss David's behavior periodically. By the end of the term David's verbal behavior was greatly improved.

Because of the pressures of time and the inadequacy of funds, many teachers work with classes of disturbed children without the aid of a mental health team. This is unfortunate. No one person alone can understand the needs of all the children in a class for maladjusted children. Some teachers have been hurt by trying to do so; in some instances the special class has degenerated into chaotic destructiveness.

In brief, a working team that includes the teacher and mental health specialists can perform five essential functions to enlarge the potentialities of the special class for helping disturbed children:

1. ***Supporting the teacher:*** The knowledge that she is working with others toward a common goal can keep a teacher from becoming prey to discouragement, anxiety, and the feeling of being hopelessly overburdened. The team also provides her with an outlet for expressing the strong feelings that inevitably arise over the frustrations encountered in working with disturbed—and disturbing—children.

2. ***Providing vital information:*** Team members of different professions are equipped to gather and interpret special kinds of information relevant to working with a disturbed child. Psychiatric interviews, psychological tests, data from social casework histories, and medical records may be critical in shedding light on the meaning of a child's behavior and on possible approaches to helping him.

3. ***Acting as a sounding board:*** The team helps the teacher become more aware of her own attitudes, feelings, and behavior and how they influence individual and group dynamics, and gives her perspective for evaluating her ideas and plans and the occurrences in the classroom.

4. ***Participating in the formulation of plans for individual children and for the group:*** The team helps the teacher set realistic expectations and appropriate goals, and suggests approaches to specific problems.

5. ***Providing, or arranging for, supportive services:*** These may take the form of family counseling, individual psychotherapy for the child, or an after-school recreation program.

In summary

The standard kind of educational planning often fails in a classroom for the emotionally disturbed because it is based upon premises about children that do not always hold true for seriously disturbed children. What the teacher who is new to this type of class must do before, during, and after giving her attention to content, methods, and materials, is strengthen her insight into the personality dynamics, perceptions, beliefs, abilities, and disabilities of these children. The most difficult aspect of planning for disturbed children is the translation of such insight into appropriate goals, methods, materials, and educational content.

Many of the principles I have here outlined for teaching special classes of emotionally disturbed children are also relevant for teaching regular school classes. It would indeed be hard to find a classroom that did not house two or three "difficult" or "difficult to get to" children. Better insight into the effective communications between teachers and children, reexamination of the relevance of standardized teaching methods and content, and planning individually for troubled children by a team of mental health specialists and educators might lead to radical improvements in many schools in which behavior problems are rampant.

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[1] The Elementary and Secondary Education Act of 1965, Public Law 89–10. Title I, sec. 201.

[2] The Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, Public Law 88–164. Title III.

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A HEALTH SERVICE PROGRAM for children in day care

FANNIE EISENSTEIN

"I don't want to lie down on the couch, I want to lie on your lap," said the little 4-year-old girl at the day-care center to the doctor from the Communicable Disease Center (CDC) of the U.S. Public Health Service.

"OK," he replied, "climb on."

"Stick me easy, man," she requested, settling down on his lap and holding out her arm.

He "stuck her easy" and drew out a specimen of blood.

For this little girl and the other children at the day-care center it had been a big day—they had made two trips to the teachers' lounge to see the doctor: trip number one for measles vaccine shots, trip number two to give blood specimens. Both trips were made as part of a demonstration project and health program being carried on with the assistance of CDC by the Gate City Day Nursery Association of Atlanta, Ga., which operates six day-care centers for children of low-income Negro families in Atlanta and nearby Marietta.

The health program has four objectives: (1) the prevention of ill health in young children; (2) the expansion of direct health services; (3) the education of teachers, parents, and the community on the needs in child health; and (4) effective cooperation between parents, the association, and CDC in health research programs.

Most of the children in the day-care centers come from families in which the mother works, often as its sole support, and of which the mother is the head. Therefore, problems of fatigue, poor pay, and long hours crowd to the fore when these mothers try to provide for their children's health.

The program begins

As they worked with the children and their parents, day-care workers at the centers realized there was a need for more health care for children than the center offered, for it only checked initial immunization and provided periodic health examinations. In September 1965, the Community Organization Department of Atlanta University School of Social Work developed a block placement as a community worker for me as a second-year student. In consultation with my field supervisor, the executive director of the agency, and the agency's medical consultant, I began the health program. Through the program, cooperative relations with local health centers were extended and regularized and caseworkers at the day-care centers, the center directors, and the student community worker (myself) met with public health nursing supervisors and district nurses to discuss and plan for health projects.

One of the first projects was to test the eyesight

of all the children at the centers with the cooperation of the Georgia Society for the Prevention of Blindness. When the tests indicated that further medical examination was necessary, parents were informed of the need, and the caseworker helped parents with referrals and appointments, as needed.

In all, the society's team recommended further examination for 18 children, most of whom were consequently fitted with glasses at private or public clinics or by private physicians. In addition, the Ben Massell Optometric Clinic, part of a private agency serving low-income people in Atlanta, gave the agency's social workers useful information on perceptual testing and training materials for preschool-age children. Each center received printed instructions on perceptual exercises and material with which to conduct daily group programs.

We also developed a program of dental education, examination, prophylaxis, and treatment with the cooperation of the Ben Massell Dental Clinic. Although emphasis in the dental program is on prevention—on the topical application of fluoride and on education—it includes extraction and restorative work.

The clinic sets aside a morning a month for each day-care center. A caseworker and the student community worker take seven or eight children at a time to the clinic in the association's station wagon as a field trip. The first round of trips—for children with the most glaring needs—has been completed; the second round is under way. Appointments for further dental care are made at the clinic as needed.

Because the Ben Massell Dental Clinic, overcrowded and understaffed like most clinics, could not give us all the time we needed, we sought the help of the dental division of the Fulton County Health Department. The department told us that during the school year it was so swamped with the work of examining the teeth of schoolchildren it could not consider taking on a program for preschool-age children. The director of the county dental division, however, agreed to include in the schedule for the summer months dental examination and the topical application of fluoride for the children in the day-care centers who had not been taken care of by the Ben Massell Dental Clinic. This part of the program was accomplished last summer.

In the conference with local health centers, we raised the question of getting measles vaccine for the children in the day-care centers. The health workers thought the idea commendable, but said that vaccine was not available for want of funds in the county and the State. We had to turn in another direction for support.

Service and research

On the hunch that where general funds for universal provision were lacking special funds might be available for a research or a demonstration project, we discussed the matter of a demonstration project on measles vaccine investigation with the Communicable Disease Center in Atlanta. From the discussion we found we could not only get vaccine for our children but could also take part in a general health surveillance program. The center was eager to explore the possibility of conducting a surveillance program involving preschool-age children in a normal community. A demonstration program was arranged, therefore. The essence of this cooperative venture between parents, the Gate City Day Nursery Association, and the Communicable Disease Center is the coordination of health programs for the children with the research and surveillance programs of the Communicable Disease Center.

A method of closely watching illness among the children was developed to permit the systematic collection of data and the early detection of outbreaks of illness. Absences and the medical reasons for absences are noted on the weekly attendance records for all children in the six day-care centers. The basic information for the surveillance and tracking procedures of the CDC staff is provided by these records; a history of the health of each child based on the center's information on immunization, past and present illness, allergies, therapy, and family health; and blood specimens (taken, of course, only with the permission of the parents). As needed, more specific and detailed information is obtained from the parents by telephone or on home visits by physicians from the Communicable Disease Center and staff members of the day-care centers.

What **Fannie Eisenstein** has to say in this article about the Gate City Day Care Centers is drawn from field experience as a graduate student at Atlanta University School of Social Work assigned to the project. She is now research director of a program aimed at turning potential teenage violence into social action, sponsored by the United Community Centers of Brooklyn, N.Y. She has also directed the nursery schools of the Jewish Community Centers of Denver.

The program has three parts: care (direct service), study (research), and education. Each part of the project has its own objectives.

The direct service program has three major objectives: (1) immunization of the children against measles; (2) immunization of the children against influenza; and (3) provision of comprehensive medical consultation.

The research program has two major objectives: (1) to study all outbreaks of illness when they occur in the day-care centers; and (2) to study the booster effect of exposure to measles among children immunized or naturally immune to the disease.

The major objectives of the education program are two: (1) to accent prevention in safeguarding the health of young children; and (2) to interpret to parents the relation between study, care, and prevention.

Vaccination activities

When the idea of the study was first broached, several staff members raised the question of how parents would respond. To insure that their response would be tied to knowledge and understanding of the program, we sent all parents a packet of three simple items: a letter explaining the program and its purpose; a fact sheet on measles vaccine explaining what it does, why it is needed, who should get it; and a permission form. Moreover, we encouraged them to call or come to the centers if they had questions. The centers followed the same procedure for their influenza vaccine program.

Permission was received from the parents of 137 children authorizing the centers to give measles vaccine and to take blood specimens. In addition, several parents added notes to the permission form saying their children had already had the measles but giving us permission to take blood specimens.

The 137 children included almost all of the preschool-age children in 5 day-care centers who, to their parents' knowledge, had not had measles.

The sixth center, the Bowen Homes Day Care Center, did not participate in this part of the program because 15 cases of measles were reported before we were ready to start the vaccination. After studying the dates of incidence and the pattern of spread of the disease, CDC physicians decided it would be useless to give measles vaccine at Bowen at that time. However, they gave 137 injections and took 133 blood specimens at the other centers (the physician found it too difficult to draw blood from 2 children; the other 2 were picked up by older brothers or sisters before he had time to take specimens from them).

We discovered later that the children at another center, the Lyman Homes Day Care Center, had already been exposed to measles—one little boy had come down with the disease 12 days before the administration of the vaccine. The vaccine, therefore, was given too late; measles broke out at Lyman. The center explained to the parents what had happened and answered their questions about the vaccine, the disease, and so forth. Although distressed that they could not prevent the outbreak of measles, center workers did get information for research on time as an element in the administration of measles vaccine that proved valuable to the CDC research program. Now that surveillance records are being filed every week with CDC, this kind of error should not recur.

Information was gathered at the Lyman Homes Day Care Center and from visits to the homes of the children by members of the CDC medical team and the center's caseworker. Parents were interested and even excited by the idea of their children being involved in a health study program and cooperated fully with the physician in pinpointing time and symptoms and constructing histories.

During a discussion about the influenza vaccine at the Bowen Homes Day Care Center, parents said they were interested not only in the vaccine but also in the facts that the physicians were concerned for children and were trying to learn new things. They raised no objection to having two blood specimens drawn, one at the time of vaccination, the other a month later. They said they were glad to participate in this kind of medical program because it would help their children and other children as well.

Thus, the centers are cooperating not only in extending direct services to their day-care children, but also in widening the knowledge on communicable disease in all children.

Had measles vaccine been available through the local health centers when we first checked this year, the outbreaks at Bowen and Lyman could very likely have been prevented. The county health department recently announced that vaccine may be available in Georgia before the end of the year.

Parent education

Many questions came to mind when we started this health care program, notably this one: Are we taking over for the parents, doing the job they should be doing for the health and protection of their children?

We found that we could not examine the question of policy without examining the situations that the parents faced. The many mothers who were the sole support of their households faced the loss of not only a day's pay but also of employment if they took a day away from their jobs, which are mostly as domestic servants or in cleaning services in hotels, department stores, and offices. The loss of a day's pay could mean having to go without several meals. Could any mother ask her family to go hungry at the moment to prevent future pain?

The fact that the day-care centers organized the provision of medical care, for example, and took children in groups to the dental clinic did not relieve the mother of her concern for her children's teeth: Often our work animated her concern, made it possible for the first time for many mothers to think about ways of dealing with the problem of their children's teeth not on an emergency basis only, when pain comes like a blow and decay is in progress, but also on a preventive basis, which underlies the importance of care and prophylaxis. The mothers' concern and interest showed in the special care with which the children were dressed on the days they had appointments at the clinic.

The caseworker or a social work student on field placement (first-year casework student) saw every parent whose child went to the clinic and explained the program, recorded the information required for eligibility, and had the parents sign the child's registration form.

Every parent was informed by telephone or letter of the work done at the clinic—such as the topical application of fluoride, cleaning and polishing, extraction and restoration.

There are three ideas behind the parent education program. The first is that there is a reinforcing relationship between expectation and aspiration. The more opportunities that become possible in the way of health, the more parents want for their children. The second idea is that of providing a model of what a child should have available in health services and what he has coming to him. The third is that of community responsibility. Safeguarding the health of children is the responsibility of the entire community—parents, special agencies serving children and families, and governmental agencies that supply resources for expanding knowledge and health.

Some changes

The program brought about changes in other directions, as well as in health. During the eye-testing project, for instance, several teachers in the centers became more keenly aware of the children's levels of response and were able to reshape methods of presenting games and play accordingly. It also brought opportunities to the children for new experience of social value. Visits to the Ben Massell Dental Clinic, for instance, provided an opportunity for Negro and white children to meet normally and casually while waiting for the dentist.

Cooperating in filing the absenteeism reports with the CDC for their surveillance records sharpened the day-to-day knowledge of our casework staff to absence due not only to illness but also to conditions in the home. The centers had always kept accurate attendance records and workers always asked parents to inform the centers of the cause of absence, but the additional purpose of helping health research and surveillance puts a renewing accent on the meaning and purpose of the procedure for both parents and staff members.

The broadening of the health program brought more of the community into the day-care centers, for instance, the volunteers who administered the eye-testing program for the Georgia Society for the Prevention of Blindness and the medical teams of the Communicable Disease Center.

The health program was reinforced by other programs developed through the community organization fieldwork placement. These included a children's theater program sponsored by the day-care centers in the communities served; an information service on jobs, training, and examination for teenage brothers and sisters of the day-care children by the centers; and involvement of parents in citizen action in the community.

SOCIAL STRATEGISTS for URBAN DEVELOPMENT

some impressions of the 13th International Conference of Social Work

KATHRYN CLOSE

More than 2,700 persons from 74 countries attended the Thirteenth International Conference of Social Work in Washington, D.C., from September 4–10, 1966—the first meeting held by the conference in this country since its postwar reconstruction in Atlantic City and New York in 1948. With the theme "Urban Development—Its Implications for Social Welfare," the participants were faced with a problem clearly urgent in nearly every part of the world: how to combat the dehumanizing effects of the increasingly rapid urbanization of the world's population. One implication was repeatedly identified from the speakers' platform and in reports prepared before and during the conference: Social workers the world over must become social strategists and play an integral part in the physical, economic, and social planning for urban development.

Twenty-seven countries had prepared reports for the conference, and there were noticeable similarities in the points these made as in many of the speeches and in the reports of the concurrently meeting commissions and study groups. They pictured sprawling, disorganized metropolises, choking from inability to digest the hoards of people flocking to them; and of vast slums packed with newcomers ill-prepared educationally, vocationally, or culturally for urban living, and confused, despairing, and hostile because of their inability to find employment, decent housing, or social acceptance. They described the resulting individual, family, and community disorganization: the devastating psychological effects of rootlessness among young people cut off from large extended families, traditionally the providers of direction and support; the alienation experienced by men who find themselves shut off by hostility or indifference from access to the affluence they see around them; the breakdown of parental controls in families where the children rather than the parents are the transmitters of the new mores.

Common problems

"Developed" and "developing" countries were reported as experiencing the same problem, differing only in degree and pattern. The developing countries are still largely rural but with a pace of urbanization far more rapid than in the developed countries, in some instances tripling or quadrupling the population of cities in a decade. In Africa, for example, the populations of Accra, Ghana, and of Luanda, Angola, have tripled in the last 10 years and that of Conakry, Guinea, has quadrupled in 5 years. In Latin America, in the 20 years following 1940, the populations of São Paulo, Brazil, Lima, Peru, and Mexico City, Mexico, tripled, while in Caracas, Venezuela, the population increased 5 times. In Hong Kong, the population has increased from 600,000 to 4 million in the last 20 years.

On the other hand, in some highly developed countries, which have become almost completely urbanized, the pace of urbanization is slowing down: Great Britain, Belgium, and the Netherlands, for example, are now between 75 and 80 percent urban; the United States, 70 percent; Canada, nearly 70 percent.

Predictions that the population of the world would be doubled within 34 years lent the conference a sense of urgency. In the United States, for example, the total population is expected in 44 years to reach 400 million, exceeding the present population of India, and 95 percent to be living in urban areas; while in India the population is expected to reach nearly 1 billion in the same period. One prediction for the city of Madras put the population at 80 million by the year 2050.

From everywhere came reports of inadequate housing. In the developed countries the cities have tended to decay at the center as the oldtime population flees to the outskirts for more air and space and—when racial differences and prejudices are involved—to escape the newcomers. In the United States, it was reported, the creation of new housing has fallen far behind the creation of new slums.

In developing countries, the slums are usually shanty towns around the rim of the cities, which provide them with no services of any type. One-twelfth of the population of the world, it was reported, are living in such shanty towns. Hong Kong is not only rimmed but topped by shanties. There, among the 620,000 "squatters" who live in illegally built, makeshift shacks are 58,000 who

dwell on the top of tenement houses. In Calcutta, India, where nearly one-third of the population live in slums, about 30 percent of the slum dwellers live in one-room "homes," shared with two other families, 15 percent live in shops, and 17 percent have no homes at all.

Resources for coping

While the dehumanizing effects of runaway urbanization were described as similar in all parts of the world, the countries' abilities to cope with them were not. The developed Western world, it was maintained, has the resources, energy, and technical ability to remake the physical, economic, and social environment into a rich and diversified garden in which every man could find nourishment for his highest potentials.

But the developing countries were said to be caught in a bind—with resources too undeveloped to produce the technical capacity for appreciable development without outside help. In some of these countries, the need for economic development was said to be so overwhelming as to overshadow the need for social programs. However, the fact that in so many of the newly independent countries a minister of social welfare was one of the first government officials appointed was cited as evidence that the social needs of people were not being overlooked. Some delegates from these countries saw in their newness an opportunity to avoid the mistakes that have been made in the old cities of the developed world.

Directions for planning

Nearly all speakers and reports advocated interdisciplinary planning in anticipation of population movements as essential. But they differed in suggested directions.

There were those who spoke up for the values of rural life—close family and neighborhood ties, the absence of clutter, the less frantic pace of living, an adherence to traditional religion. They suggested that the rush to the city could be slowed down by efforts to improve the access for rural people to good medical care, jobs, social services, and stimulating leisure-time activities.

The gaps between rural and urban life were reported to be widening in some of the developing countries. Some reports, however, pointed out that the gadgets and manners of urban living are as familiar to country as to city dwellers, at least in some parts of the developed world, through "the invasion" of the country by city commuters, the decentralization of industry, the omnipresence of the automobile, the multiplication of roads, and especially the mass media of communication. But not all the effects of this rural urbanization were presented as salutary. For example, in one highly developed country of Europe where rural villages have been invaded by city commuters, newly created class distinctions have resulted in resentment and friction.

Many conference participants, however, saw no need to arrest the trend toward urbanization, nor indeed any possibility of doing so, but a great need to build urban environments in both new and old cities that would fulfill the city's function as a civilizing force. Such planning, it was asserted, must begin with the recognition that what young people are seeking when they flock to the city is the chief advantage of urban life, the possibility of making independent choices—in jobs, friends, services, training, intellectual pursuits, consumption, and leisure-time activities.

Seeing that the urban environment actually provides this possibility of choice is a task of the social worker, it was maintained, as is seeing that rural people are helped before and after migrating to the city to know what to expect there and what is expected of them.

Some of the values of rural life might be retained, it was said, if an "ecological approach" were taken to urban planning—an effort to retain the relationship of man to nature and to avoid exploitation of either.

Architects and town planners on the program described new towns being built in England, the United States, Brazil, and Venezuela and called for social work participation in helping planners provide for human needs. One warned that unless new towns were "socially balanced" they would become "rugs under which the poor are swept." Another spoke of the immediate necessity of providing slums, "a semi-permanent fact of modern urban growth," with the basic services to sustain family life, encourage upward mobility, and develop community life—sanitary facilities, garbage collection, playgrounds, schools, vocational training centers, and churches.

A sense of community

Social planning, the conferees were repeatedly reminded, implies attention not only to the provision of social and health services, but also to the means for people to develop a "sense of community," particularly lacking in the slums. Thus social workers were urged not only to take steps to see that the kinds of facilities and services that encourage neighborliness and community involvement are strategically located, but also to encourage the "maximum feasible" participation in policy decisions of the people to be affected by them, "rich and poor alike," youth as well as adults.

Methods suggested to bring about such participation were: the decentralization of government to make it more responsive to local needs, as in the Basic Democracies of Pakistan; the application of community development techniques used in the villages of India; the organization of community action committees as in antipoverty programs in the United States; and the establishment of multipurpose neighborhood service centers to give people a channel for voicing their needs and wishes. There was, however, a warning against allowing self-appointed pressure groups to usurp the role of elected representatives of the people.

About children

Children received attention at the conference chiefly as the victims of the family disorganization resulting from rapid urbanization: lost, homeless children who band together to form substitute families of their own; children used as messengers in a rampant trafficking in drugs; children unprotected from all the health hazards of overcrowding and lack of sanitation and water; children emotionally abandoned by despairing parents; children subjected to the thousand daily indignities of conscious and unconscious racial discrimination.

In the study group on children, composed of 45 persons from 19 countries, the differences in service needs because of differences in country resources and

customs became evident. For example, neither homemaker services nor income maintenance programs—considered necessary in most countries of Europe and North America—are regarded as feasible in countries where large extended families are still predominant. However, where the extended family system is still strong, countries generally rely on institutional care rather than on foster family care or adoption for homeless children or children born out of wedlock. On the other hand, interest in the provision of day-care services for children of working mothers seems to be growing everywhere because of increasing participation of women in the labor market.

The study group discussions revealed also that differences in resources and stage of development between countries account for differences in service priorities. Many developing countries give "human investment" programs such as vocational education priority over individualized services for children with special handicaps, leaving the total well-being of all children as a "goal for tomorrow." In countries with more highly developed resources, however, greater emphasis is put on refining services to children with special problems, such as taking steps to individualize services for children and adolescents brought before the courts for delinquency or neglect.

A discussion of family planning services in this study group revealed great disparity in the availability of such services among the 19 countries represented, but also some evidence of a growing interest in changing prohibitive government policies. In England, for example, help with family planning is provided to married women only, but there is increasing discussion about the advisability of extending the service to unmarried women. In France, where help with family planning can only be provided clandestinely, a well-publicized movement seeks to mobilize public opinion for a policy of approval. In India and Pakistan widespread family planning services receive strong government support. On the other hand, in some countries of South America family planning services are strictly forbidden and all but unknown.

Despite these differences in emphases, the study group on children arrived at a number of targets for social work efforts. These included services to strengthen family life (all representatives indicated this as an expressed goal in their countries); services to supplement family care in urban development; comprehensive and coordinated health and educational services for children; increased social work research; changed professional and public attitudes in relation to such areas as family planning, adoption, unwed mothers and their children, and more balanced service for girls; adherence to the UNICEF declaration on the rights of the child; the development of a national policy in relation to children; and a more competitive approach toward securing a fair share of funds for social purposes beamed toward preventing future problems as well as protecting children.

Social work education

There was explicit recognition in the conference, as there had been at the International Congress of Schools of Social Work held the previous week, that if social workers are to play a more forceful role in urban development those responsible for social work education must lift their sights to take this into account.

One proposal was for the development of two types of social workers—the traditional caseworkers and group workers, trained in the diagnosis and treatment of individual and social problems, and social strategists with knowledge of economics, tax structures, laws, and politics, trained to work at policy levels with government officials, industrialists, and legislators. Schools of social work, it was also suggested, should work more closely with schools of architecture, public health, education, and other units of universities, including the new institutes for the study of urban problems. But proposals that greater emphasis be put on training social work generalists, geared to social action, brought some expression of fear that the special nature of the social work profession might be lost.

The need for expanding schools of social work everywhere, but especially in the developing countries, was repeatedly stressed. Some delegates deplored the modeling of social work in their countries on the U.S. pattern and advocated that aid efforts be focused on helping them build up their own schools with training closer to their countries' needs and culture. The United States, it was maintained, could learn a great deal from some of the developing countries about the usefulness of indigenous "social animators" and mutual aid associations in bridging the cultural gap between the professional and client, as well as in alleviating the social work manpower shortage.

A force for civilization

There was a great deal of emphasis in the conference on the importance of research, on the need to know more about the way people live in neighborhoods; about why they do or do not use the services provided them; about how to measure the effectiveness of services.

But the conferees were also warned against an excess of professionalism lest it lead to "the indifference of wisdom" and add to the technical age's greatest threat to civilization—destruction of man's sense of identity and hence his relationship to his fellowman. Calling for "an excess of feeling, of caring, and decency" one speaker maintained that as "a prime civilizing force" social workers must "force world society to recognize that people die inwardly from being nameless and faceless, from not having roots in the community . . . and from having to react endlessly to a thousand small, uncaring ways."[1]

The conferees responded to this challenge with a standing ovation—perhaps an indication that in it they recognized the ultimate goal for developing the reach and skill of social work.

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[1] Young, Whitney M., Jr., executive director, National Urban League, New York.

HERE and THERE

White House Conference

The first steps toward a 1970 White House Conference on Children and Youth were taken last August by the Secretary of Health, Education, and Welfare, John W. Gardner, when at the request of the President he wrote to the Governors of the 50 States, Puerto Rico, Guam, the Virgin Islands, and American Samoa and the president of the Board of Commissioners of the District of Columbia asking for their support. In the letter, the Secretary asked each Governor to appoint a State committee to plan for the State's participation in the Conference, to act as liaison between the Governor and a national committe to be appointed by the President, and to work with the staff of the national Conference. The Conference's staff will be attached to the Children's Bureau.

By mid-October, the Secretary had received 36 affirmative responses. In most States, the Governor had appointed or was about to appoint an already existing State committee for children and youth to work with him for the proposed 1970 Conference.

Family planning

Whether or not unmarried women and girls should have access to family planning services came under discussion at two meetings focused on public family planning services, held in September. One, in Roanoke, Va., September 7–8, was sponsored by the Department of Health, Education, and Welfare for persons in key positions in the health, education, and welfare programs within the 12 Appalachian States. The other, held in San Francisco, Calif., September 19–20, was sponsored by the Searle Reference and Resource Program for persons engaged in the operation or support of public family planning clinics.

The Roanoke meeting was the first of nine regional meetings on family planning planned by the Department, the others to be held in Atlanta, Dallas, Kansas City, Denver, Chicago, New York, and Boston. Its 200 participants focused their attention on the current availability of family planning programs, the social and economic aspects of providing them in various types of settings, and the resources for supporting educational, research, and service programs in family planning. The discussion revealed general agreement on the importance of access to family planning service for married women at all socioeconomic levels, but divided or uncertain opinions on when, if ever, such service should be provided to unmarried women or girls.

At the San Francisco meeting, where similar ambivalent attitudes were reported to be held by some workers in this field, the dinner speaker, Katherine B. Oettinger, Chief of the Children's Bureau, put family planning services in a framework of health and family protection and urged their extension to all who need them. Pointing out that 50 new maternal and infant care projects and many other maternal and child health programs supported by Federal-State funds do offer family planning services to unmarried mothers who have already produced a child, she said that the best possible health, education, and welfare resources should be made available to minimize the problem of unwanted and irresponsible pregnancies, especially among teenagers, the group "most vulnerable" to unstable family relationships. She especially stressed the need for family life education and sex education from preschool through college levels.

Other sessions of the San Francisco meeting were focused on strategies for educating the community to the purpose of a family planning clinic, methods of reaching and keeping the client, ways of planning and evaluating a clinic's objectives and progress, and resources for support.

For youth

Young parents are to be the first focus of a new Children's Bureau program of youth services directed at facilitating the transition of all youth to responsible adulthood. The program, which is being developed through the Bureau's newly established Youth Services Unit, under the leadership of Dr. Catharine V. Richards, will be directed toward identifying the problems and needs of adolescents and young adults in today's changing society, exploring existing resources for meeting these needs, and stimulating new approaches for dealing with them. Its long-range goal is to promote the development of a network of synchronized public and voluntary systems capable of providing a social structure in which young people can develop their potentialities as individuals and as competent contributors to the maintenance and development of democracy.

Both married and unmarried young parents were chosen as the first concern of the new program because the high risks of unstable family relationships in these young people are a detriment not only to their own well-being but also to the well-being of their children and of society. It has been estimated that 600,000 girls between the ages of 14 and 19 have children, and that 40 percent of the more than 250,000 children born out of wedlock each year are born to girls under 20. Figures from some States also indicate that marriages of teenagers break up in divorce three to four times more frequently than other marriages.

The new program will, therefore, work toward the promotion of sex education and family life education through public and voluntary agencies, to supplement what is being done in this direction through the schools; the extension of community programs of parent education directed especially to young parents; and the provision of

integrated medical, psychological, educational, and social services to unmarried mothers.

Dr. Eleanor Brown Luckey, specialist in family life education at the University of Connecticut, will spend a year at the Children's Bureau, on loan part time from the university, to help get the program for young parents under way.

. . .

The first of five projected conferences of representatives of State committees on children and youth to identify the problems of young people today and possible directions for meeting them was held in Washington, D.C., September 22–24, under Children's Bureau auspices. The 18 participants came from committees in Delaware, Maryland, New Jersey, Pennsylvania, West Virginia, and the District of Columbia, and included three youth representatives—two high school students and one recent college graduate.

One of the problems the participants identified as most important was the widening of the distance between the generations by the rapid technological developments and social changes of the day and the consequent need of parents and other adults for help in understanding and relating to adolescents. Other needs stressed were: cooperative activities between adults and young people in community planning and improvement; increased and challenging opportunities for young people—commensurate with their abilities and energy—in education, employment, community service, and participation in community affairs; widespread opportunities for young people to build close relationships with their peers and with adults in an increasingly impersonal society; and greater cooperation between organizations interested in the welfare of youth at Federal and State levels and in communities and neighborhoods.

Similar conferences with the purpose of assessing conditions and suggesting action for change were held in Boston, Mass., and Atlanta, Ga., in October and will be held in Omaha, Nebr., and Salt Lake City, Utah, in November.

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Three hundred teenagers attended conferences on youth and alcohol at Kane and Meadville, in northwestern Pennsylvania, September 30 and October 1, respectively, the first such conferences to be held in six geographic areas of the State, under the sponsorship of the Governor's Advisory Council on Alcoholism and the Committee on Children and Youth of the Governor's Council for Human Services. The area conferences are the result of a statewide conference on youth and alcohol held in Philadelphia last April under the same auspices and are intended to generate additional conferences on countywide bases, thus reaching young people in every part of the State. Their purpose is to give the young people an opportunity to express their ideas on the extent of and reasons for drinking among teenagers, to provide them with information about the chemical reactions of alcohol on the body and the nature of alcoholism as a disease, and to strengthen their ability to make wise decisions in relation to drinking.

A questionnaire answered by 143 of the young people who attended the statewide conference indicated that 68, or nearly half, drank once in a while, usually to celebrate an occasion or simply for enjoyment.

Family life education

Under a policy issued late in August, the U.S. Office of Education has made clear its willingness to offer financial help, under its already established programs, to educational institutions and community agencies to start or to improve programs in family life education and sex education. The offer applies to all levels of educational programs from preschool through graduate programs, including programs for adults and educational research. The funds may be used not only for classroom instruction in sex education and family life education but also for the training of teachers, counselors, and health workers in these subjects.

Projects on or including family life or sex education are eligible for support through these Office of Education programs: aid to schools in low-income areas; supplementary centers and services for elementary and secondary schools; university leadership for urban progress; vocational and technical education; counseling and guidance institutes; institutes for advanced study; adult basic education programs; educational research and training; and library services and construction. Initiation of such projects and their substance remain a matter of State and local choice. In most Office of Education programs, Federal funds are channeled through State agencies.

The Office has prepared fact sheets about the program through which support for family life education can be received and guidelines for applying for funds under title I (aid to schools in low-income areas) and title III (supplementary centers and services) of the Elementary and Secondary Education Act of 1965.

Social work training

In a two-way program conducted last summer—two way in that it was designed to benefit both instructors and students—121 faculty members from 31 schools of social work spent from 3 weeks to 3 months in public welfare agencies in 25 States, the District of Columbia, and Guam on projects demonstrating new methods or new uses for existing methods of administering federally aided public assistance programs. Through the projects, social workers and supervisors received on-the-job training under the faculty members, and faculty members had opportunities to gain field experience that could broaden the base of their teaching.

In one State, for instance, six faculty members, working with the program planning and development staff of the State welfare department, prepared guidelines for social workers to use in assisting welfare clients and low-income families. In another, nine faculty members conducted intensive training programs for caseworkers with little or no academic training. In a third, two faculty members worked as consultants to students from schools of social work who were receiving on-the-job training during the summer.

Demonstration grants totaling almost $312,000 from the Welfare Administration of the U.S. Department of Health, Education, and Welfare supported the program.

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During fiscal year 1966 (July 1965–June 1966) the Children's Bureau awarded about $5 million in grants to 66 schools of social work and to 2 other higher education institutions in 33 States, the District of Columbia, and Puerto Rico to conduct projects in professional training under the child wel-

fare training grants program. The program supports three types of projects: teaching programs for field instructors and other faculty members; traineeships at both the master's and doctoral levels; and short-term training programs, all for persons working in or intending to work in the field of child welfare. By categories the 1966 grants were made as follows: 154 teaching grants totaling $2,428,317; 727 traineeships totaling $2,399,275; and 21 short-term projects totaling $172,391.

The amounts granted have increased each year since the program began in 1963. In fiscal year 1963 the Bureau granted $199,133; in fiscal year 1964, $1,805,444; and in fiscal year 1965, $3,578,579.

International health

The Children's Bureau recently added two new aspects to its international research program in maternal and child health: (1) the provision of opportunities for U.S. experts to study problems and developments in other countries and for experts from other countries to come to the United States for study, observation, and consultation; and (2) the provision of opportunities for senior medical students in this country to engage in short-term research studies abroad. All travel and maintenance are paid through U.S.-owned foreign currencies.

Only a few highly qualified experts, such as professors on sabbatical leave from schools of medicine or public health, will be selected for study abroad in the interchange of experts program. The medical students for the foreign research studies are being selected from referrals made by the deans of the medical schools in this country, all of which have received notice of the program. They will engage in research projects funded by the Bureau in Egypt, India, Israel, Pakistan, and Yugoslavia. Three students, selected early last summer as the first to participate in the program, have already completed studies in Egypt, Israel, and Pakistan.

The Bureau is now funding 18 research projects in different aspects of maternal and child health in 6 countries—Egypt, India, Israel, Pakistan, Poland, and Yugoslavia. These include studies of: prematurity; toxemia of pregnancy; infant mortality, morbidity, and growth and development of children of various social and ethnic groups; the incidence of and screening methods for phenylketonuria; the incidence and detection of deafness and hearing loss in children; the cause and incidence of severe mental subnormality; and the effects of the introduction of contraceptive services on the rate of abortions.

Child health

The National Institute of Dental Research (NIDR) of the U.S. Public Health Service recently announced the development of a new, easily administered, method of applying fluoride to children's teeth. By using a plastic mouthpiece, similar to those worn by athletes, a jellylike material containing 1.1 percent sodium fluoride is forced into pits and fissures of the teeth and into the gums undiluted by saliva. One dental hygienist can effectively supervise many more children with the new method than with the methods of topical application of fluoride that are now used.

NIDR tested the new method over 2 years in Cheektowaga, N.Y., a community without fluoridated water. About 300 children wore the gel-filled mouthpiece for 6 minutes each schoolday; 200 others, used as controls, were not treated but were kept under surveillance. The children in the control group developed over four times as many new decayed, missing, or filled tooth surfaces as those treated by the new method. Many of the children who were treated developed no new cavities during the testing period. NIDR points out that the findings of this test add to the evidence that fluoride strengthens the teeth and makes them more resistant to decay.

PHS plans to run two additional tests on the method: one in an area having fluoridated water to determine whether repeated topical application of fluoride confers additional protection, and another to determine the effectiveness of weekly, rather than daily, applications.

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American Indians and Alaskan natives (Eskimos, Aleuts, and Athapaskan Indians) can expect to live longer than ever before because fewer of their children are dying in infancy and their general health is improving, according to recently published figures of the Public Health Service.

The figures show that an Indian child born in 1964 had a life expectancy at birth of 63.5 years as compared with the 51 years of an Indian child born in 1940. However, a child born in 1964 in the general population had a life expectancy at birth of 70 years. The infant mortality rate among Indian children dropped 45 percent between 1954 and 1964—from 65 to 35.9 deaths of infants in the first year of life for every 1,000 live births—but was still 1½ times greater than for the general population. During the same decade, the infant mortality rate among Alaskan natives dropped 34 percent, from 83.4 per 1,000 live births to 54.8. For all other U.S. citizens the infant mortality rate was 26.5 in 1954 and 24.8 in 1964.

The incidence of respiratory illnesses, gastroenteritis, and diarrhea, the diseases that have been the leading killers of Indian and Alaskan native children, has also been greatly reduced—a fact the PHS attributes to immunization programs for children and the greatly improved conditions of sanitation under which Indians and Alaskan natives live.

Obstetrical services or conditions associated with pregnancy continue to be the main reasons for admission to hospitals for Indians and Alaskan natives. Between 35 and 40 percent of all their general patients, however, are under 15 years of age, and 70 percent of this group are under 5.

The figures are included in "Indian Health Highlights: 1966 Edition," available from the Inquiries Branch, Public Health Service, U.S. Department of Health, Education, and Welfare, Washington, D.C., 20201.

Research

To protect the rights and welfare of human beings used as research subjects, the U.S. Public Health Service (PHS) has issued two policy directives requiring assurances from all applicants for its research grants that protective procedures will be followed and that appropriate means used to gain the subject's consent. In addition, PHS is also supporting a study of the ethical questions involved in such research.

The first directive, issued on February 8, 1966, requires all institutions applying for PHS grants not only to submit such assurances of protection,

but also to supply a description of the risk involved and of the potential benefits of the proposed research. The second directive adds to these requirements assurance that the work of each individual researcher will be reviewed by and remain under the surveillance of a committee of his colleagues before human beings are used as subjects, preferably before the application for the research grant is made.

The study of the ethics of research with human subjects will be carried out by the American Academy of Arts and Sciences, under a PHS grant, through a series of conferences to be attended by physicians, medical scientists, lawyers, sociologists, and members of other professional groups. The conclusions will be published in a special issue of the Academy's journal, *Daedulus*, late in 1967 or early in 1968.

Juvenile delinquency

The 1966 Maryland Legislature has established a Department of Juvenile Services, to be the central administrative agency for juvenile correctional services in the State. The department will have responsibility for institutions for the detention, diagnosis, training, and rehabilitation of juvenile offenders, formerly administered by the State Department of Public Welfare, and for juvenile probation and aftercare services, formerly administered by the State Department of Probation and Parole, the State Department of Public Welfare, or local probation departments.

The legislation establishing the new department provides for an Advisory Board of Juvenile Services to consult with the department, consisting of representatives of the State Departments of Education, Health, Mental Hygiene, Police, and Public Welfare, the judiciary of the State voluntary child welfare agencies, and the public at large. The law also directs that a study of the State's juvenile correctional facilities and probation and parole services be made by February 1, 1967. At the request of the Governor, the Federal Children's Bureau is carrying out the study.

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The Children's Bureau is also conducting a comprehensive study of the facilities and programs for juvenile offenders in New York State which are administered by the New York State Department of Social Welfare. The study will be part of a broader study of all New York State facilities and programs for both adult and juvenile offenders being conducted by the Governor's Special Committee on Criminal Offenders.

Child care

Some 142,000 children were adopted in the United States during 1965, an increase of 4.6 percent over 1964, according to Children's Bureau estimates. The rate of increase was a little lower than for the year before, since 6.4 percent more children were adopted in 1964 than in 1963. More than half the 1965 adoptions—54 percent—were made by persons unrelated to the child, and of these, 69 percent—about 53,000—were made through social agencies—the highest proportion on record, and a continuation of a trend toward agency rather than independent placement for adoption.

An estimated 11 percent, or 15,600, of the children adopted in 1965 were nonwhite, about the same as the proportion of nonwhite persons in the population, and about the same proportion as in 1964. This proportion, however, was not sufficient to provide for all the nonwhite children in need of adoption.

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From studying 115 foster homes in which 127 disturbed children had been placed, the Foster Homes Research Project of the Wisconsin State Department of Public Welfare has drawn up a list of 10 characteristics found in most of the successful foster homes:

1. Family income was at least average.
2. The father and mother worked well as a team.
3. The family had other children (natural or foster).
4. The father had a relatively high level occupation.
5. The mother received a good rating in handling a hypothetical defiant child on a questionnaire.
6. The parents of the foster mother were not or had not been "highly" religious.
7. The father and his parents had had an affectionate relationship.
8. The mother was rated as "child centered" on an attitude questionnaire.
9. The mother lacked confidence in her ability to handle a hypothetical withdrawn child.
10. The father exercised "selective firmness."

The project set out to identify (1) the characteristics that distinguish the "relatively" successful foster home from the "relatively" unsuccessful, and (2) the ways in which these characteristics can be included in an intake study of families applying for foster children. Using the Borgatta-Fanshel Child Behavior Characteristics Schedule, social workers through interviews with the foster parents evaluated each foster home on the basis of the child's behavior in line with the goals of the placement.

Investigators for the project also conclude that more research is needed on two related subjects: methods of assessing the success of foster-home placements besides using the judgment of the social worker, and the development of precise ways of assessing the child's behavior and changes in it. Both problems are complex, they point out—particularly the second, as it involves the child's previous experience with neglect, abuse, and emotional crises and his present experience of continuing a relationship with his own family while living with the foster family. They also point out that their findings are exploratory rather than final, but that the investigation may have been "on the right track" toward identifying predictors of success.

The project was supported in part by a grant from the Children's Bureau.

. . .

As a basis for refining its programs for recruiting, selecting, and guiding foster parents, Brookwood Child Care, a voluntary child placement agency in Brooklyn, N.Y., recently developed a composite "profile" of its foster parents, based on data gathered on 59 foster-parent couples who had been with the agency prior to January 1965. Fifty of the couples were Negro.

The agency found as positive characteristics the fact that most of these foster parents had come from families that had stayed together in spite of social and economic deprivations, that they themselves were maintaining close family ties, that the foster fathers were steady wage earners, that the couples took foster parenthood seriously (as indicated by their average length of

service—5 years), that home and family were their principal interests, and that their chief reason for taking in foster children was "love of children" rather than the desire for additional income. Most of the foster parents were rated by the agency's caseworkers as "satisfactory" in dealing with behavior problems.

The chief weaknesses found by the agency in these foster parents—on the basis of caseworkers' ratings—was in ability to deal with highly aggressive children and to handle sexual problems. Another weakness—from the standpoint of the agency's needs—was the overwhelming preference among them for taking in preschool-age children and reluctance to take in teenagers.

On the basis of these findings, Peter C. Rocco, administrative supervisor, who prepared the profile, has proposed increased agency guidance of foster parents through intensified inservice training for all foster parents and an orientation course for new foster parents. He also proposed the establishment of small group residences for adolescents—a service which has since been inaugurated.

The agency is presently engaged in preparing a group "profile" of its foster children.

in the journals

The unwed father

The father of her child is "certainly not a phantom" in the life of the unwed mother, Mignon Sauber maintains in an article in the November 1966 issue of *Welfare in Review*. ("The Role of the Unmarried Father.") On the basis of information obtained from 273 unwed, first-time mothers who had kept their children, the author reports that 3 out of 5 mothers were still in contact with the fathers and that 33 percent of them had lived with the fathers at some time during the 18 months after their children were born. At the end of the 18 months, 15 percent were married to and living with the fathers; another 12 percent were living with the fathers though not married to them. The study was carried out under the auspices of the Community Council of Greater New York, of which the author is research director.

About half the fathers gave some financial support to the mothers during pregnancy, the author reports. About 64 percent of the mothers received some support from the fathers during the 18 months after the birth of their children; at least 4 out of 10 received some help from the fathers throughout the 18 months. No other source of support was so steady. Almost all of the fathers who gave support did so voluntarily. Employed fathers were the ones most likely to give support.

Mothers between the ages of 17 and 24 had more contacts with the fathers than did those under 17 or over 24. The longer the mother and father had known each other before conception, the longer they continued to have contacts after the birth of their child.

Although the information about the unwed fathers was gathered indirectly through the mothers, the author maintains that it may "add to the growing body of knowledge about unmarried fathers."

Nonthriving babies

The mother whose baby fails to thrive though he seems organically sound may need nursing care herself to help her find satisfaction in motherhood, Julina P. Rhymes maintains in the September 1966 issue of the *American Journal of Nursing*. ("Working With Mothers and Babies Who Fail To Thrive.") She draws her conclusions from a study of 13 babies ranging in age from 12 weeks to 27 months who were hospitalized because they were not thriving despite apparent organic soundness. The investigation centered on the environment of each child, especially on the mother-infant relationship.

The mothers, the author reports, had certain characteristics in common. Their families were under great stress—stress borne principally by the mother—both emotionally and financially. Most had grown up in chaotic, unstable homes lacking good mothering. They seemed unable to give their children the mothering they needed. All of the babies were the results of unplanned, unwanted pregnancies.

An important function of the nurse, she points out, is to help the baby's mother respond to him appropriately by acting not as an authority figure but as an "ally or collaborator" in the care of the baby, allowing the mother to progress at her own pace. When possible, she suggests, the nurse should urge the baby's father or other members of the family to give the mother more support.

The risks of adoption

Alfred Kadushin, writing in the July 1966 issue of the quarterly *Social Work*, answers the question he raises in the title of his article in the negative. ("Adoptive Parenthood: A Hazardous Adventure?") The hazards of adoption, he maintains, are more apparent than real.

The author reviews 11 studies that report over-representation of children adopted by nonrelatives among those referred for psychiatric clinic treatment. However, he raises questions about the statistics employed in arriving at this conclusion, citing claims by research investigators that the base used is too large and the proportion of adopted children in the population has been underestimated. Other questions concern differential use of treatment facilities and lack of clear-cut evidence that symptomatology differs for adopted and natural children.

The author also reviews studies of the outcome of adoptions. In these, he found that 78 percent of 2,000 adoptions were considered "unequivocally successful" and that only 14 percent were considered failures.

His conclusion is that "adoption can be, and most frequently is, a successful venture."

BOOK NOTES

THE ADOLESCENT GIRL IN CONFLICT. Gisela Konopka. Prentice-Hall, Inc., Englewood Cliffs, N.J. 1966. 177 pp. $4.95, clothbound; $1.95, paperback.

Because she is often lonely and in despair, the adolescent girl in conflict seeks relief in "the crowd or in the love relationship," only to find they offer temporary relief, according to this book on delinquent adolescent girls. Such girls receive very little help from society, the author contends. She bases her observations on a study made through group and individual interviews with over 180 adolescent girls in Minnesota, aged 14 to 19, of whom 100 had been adjudicated as delinquents, and 76 were in institutions as unwed mothers. The book includes many excerpts from tape recordings of the girls' conversations, which reveal their feelings about themselves, others, and their relationship with the outside world.

The author found that the offenses charged against the delinquent girls were truancy, running away from home, and illegal sexual acts, charges not usually brought against boys. Although boys probably act out sexually more than girls, she contends, such acting out is more evident in girls because of the "meaning it has to the girl herself" and because the public "is generally negative toward it for the girl while tolerant of it for the boy."

The problems of adolescent delinquent girls, the author finds, stem from such sources as being unprepared for puberty, the difficulties in adverse family situations of identifying with an adult, the changing but still anomalous position of women in society, and "faceless" adult authority. She recommends several courses of action as remedy: providing better services to unmarried mothers; improving the status of women in our society; providing constructive coeducational activities for young people; and putting current knowledge into practice in programs for delinquents.

THE ROLE OF AGENCIES SERVING LOW-INCOME GIRLS. Training Center in Youth Development, Boston University; National Federation of Settlements and Neighborhood Centers Training Center, Chicago, Ill.; Training Center for Delinquency Prevention and Control, University of Minnesota, Minneapolis. Boston University Press, Boston, Mass. 1965. 202 pp. Free on request from Boston University Training Center in Youth Development.

This publication reports on a conference on agencies serving adolescent girls from low-income families held in Minneapolis last year under the direction of Catharine V. Richards, by the three agencies listed above.

The report contains the papers that furnished the framework for the conference, notes on workshops held during the conference, and the guidelines adopted for providing services to such girls.

A summation of conference recommendations suggests four methods of intervention in working with adolescent girls: helping them build respect for themselves and others; providing experience that will strengthen their trust in themselves and others; manipulating the environment; and providing constructive experience for learning how to get along in the world.

DEPRIVATION AND EDUCATION. Mrs. M. L. Kellmer Pringle. Longmans, Green & Co., Ltd., 48 Grosvenor Street, London, W.I., England. 1965. 311 pp. 42s. 6d. net. (Obtain from William Glaisher, Ltd., 294 Croxted Road, Herne Hill, London, S.E. 24, England.)

Deprivation of normal home life can seriously affect the ability of a child to learn, the author of this book contends. She bases her conclusion on the results of a study she conducted of 142 children, ages 4 to 14, in residential care in England.

The author discusses the effect of deprivation of a normal home life on early language development; the connection between prolonged separation and emotional adjustment; differences in experience and behavior in stable and disturbed children; and the effects of remedial education on the educational attainment of maladjusted children.

The author found that—

- Language development among children in care was more seriously affected by deprivation than any other aspects of development.
- Those children who were regarded as least responsive to teaching efforts were those who had no contact with their parents and other relatives.

Pointing out that the best time to prevent language difficulties among deprived children is in the preschool years, the author recommends that—

- Nursery schools with trained teachers be provided for children from crowded, deprived homes.
- Greater emphasis be placed by caretakers of children in institutions on conversation with and reading to children, and every means used to arouse the child to express ideas, thoughts, and feelings.
- Every child in institutional care be provided a stable, long-term relationship with an adult.
- Ways be found to help inadequate, incomplete families with the tasks of child care and to ease the effect of damaging experiences on children taken into care.

GROUP WORK AS PART OF RESIDENTIAL TREATMENT. Edited by Henry W. Maier. National Association of Social Workers, New York. 1965. 175 pp. $3.25.

The first of a proposed series of publications on specific subjects related to group work, this collection of 12 essays on residential treatment reflect change in social work, according to the editor, because they are on social group work as part of, not just in, residential treatment. The essays discuss the group work treatment process before placement, during placement, and in residential living.

The examples used are largely taken from residential settings for children.

THE ADOLESCENT EXPERIENCE. Elizabeth Douvan and Joseph Adelson. John Wiley & Sons, Inc., New York. 1966. 471 pp. $7.95.

The adolescent is both "pushed and pulled toward the future," according to the authors of this report on a study of over 3,000 adolescent boys and girls in school—the "middle majority"—in all sections of the United States and from all classes of society. A basic assumption with which they began—that the "thrust to the future is crucial to the adolescent experience"—proved correct, the authors maintain. Orientation to the future was characteristic of the young people who were well adjusted in adolescence; it was markedly absent in those who were not.

Another assumption with which they began, however—that boys and girls would not differ greatly in their responses—proved false, they report. The boys concentrated on acquiring vocational skills that could lead to "modest advances" over their fathers' positions. The girls, on the other hand, concentrated on the "interpersonal . . . on marriage and the roles of wife and mother." The differences between the sexes were even more marked, the authors hold, in the relation of young people with one another. Group loyalty had much more meaning for boys than for girls. Girls gave their loyalty to "best friends"—to two-person relationships.

Despite such differences, the authors maintain, by and large, these young people were much alike in that they were "heavily invested in middle-class values" regardless of class or geographic location.

The study was conducted for the Boy Scouts of America and the Girl Scouts of America in 1955 and 1956 by the Survey Research Center of the University of Michigan.

films on child life

Charges for rental or purchase may be obtained from distributors.

A QUARTER MILLION TEENAGERS. 16 minutes; color; sound; purchase.

Designed for use in health and science classes and as a tool in the national program to combat venereal disease among teenagers, this discussion film is directed to teenage audiences. One sequence stresses that VD can be cured if treated in the early stages; animated sequences explain in detail the physiological aspects of syphilis and gonorrhea.

Audience: Junior and senior high school students (in health, biology, and physiology classes); youth groups; student-teachers and other adults who work with adolescents.

Produced by: Churchill Films in cooperation with the Los Angeles City Schools and the Los Angeles County Health Department.

Distributed by: Churchill Films, 662 North Robertson Boulevard, Los Angeles, Calif., 90069.

WILLIE CATCHES ON. 24 minutes; black and white; sound; purchase.

Using a biographical technique, this open-end film depicts the environmental influences which develop and perpetuate attitudes of racial prejudice in a growing child. The film depicts Willie, a racially prejudiced college student, as a victim of his otherwise advantaged environment and of his own prejudices. It points out the influences present during various periods of his development and traces the progress of his prejudice from infancy to college age.

Audience: Parents and expectant parents, teachers and student-teachers, youth groups and group leaders, and community groups.

Produced by: National Film Board of Canada.

Distributed by: Text-Film Division, McGraw-Hill, 330 West 42d Street, New York, 10036.

TO OPEN A DOOR. 30 minutes; sound; black and white; free loan.

Designed to illustrate the effectiveness of community cooperation in promoting medical programs and financed by a grant from the Public Health Service, this film shows the methods used by one community to reach the segment of its population most in need of health aid and information. Volunteers from all walks of life—including children and teenage gangs—in Newark, N.J., make up the cast.

Audience: Civic and PTA groups concerned with community health and welfare; State and local public health officials; political leaders; clergymen.

Produced by: New Jersey Department of Health in cooperation with the U.S. Public Health Service.

Distributed by: U.S. Public Health Service Audiovisual Facility, Communicable Disease Center, Attention: Distribution Unit, Atlanta, Ga., 30333.

THE NEGLECTED. 30 minutes; sound; black and white; purchase.

Sponsored by the Children's Bureau and the Pennsylvania State Department of Welfare, Office of Children and Youth, this film portrays the many kinds of impoverishment in families whose children are in the care of a community agency because of abuse or neglect. It demonstrates how skilled social workers can help families change harmful relationships that threaten the health and emotional well-being of their children.

Audience: Child welfare agency personnel; community mental health organizations; psychiatrists; others interested in community child protective services.

Produced by: Affiliated Film Producers.

Distributed by: International Film Bureau, Inc., 332 South Michigan Avenue, Chicago, Ill., 60604.

READERS' EXCHANGE

HROMADKA: *Important activities*

I was reassured to find in the Chambers-Foster article describing the University of Pittsburgh courses for child-care workers that such preparatory training for child care is possible and workable in the United States; and also to find Mr. Hromadka again stressing the need for such training. ["Toward Improved Competence in Child-Care Workers: 1. A Look at What They Do," by Van G. Hromadka; and "2. A Two-Level Training Program," by Guinevere S. Chambers and Genevieve W. Foster, CHILDREN, September–October 1966.]

However, while we hope the near future will bring more extensive courses both to prepare workers as well as to give training to those already on the job, we should also recognize what is already being done across the country, here and now. This year the University of North Carolina School of Social Work commemorated the 20th year of summer workshops for child-care workers; St. Louis University had its 10th anniversary of month-long institutes. There are a number of week-long institutes each year at, among other places, Minneapolis, Minn., Syracuse, N.Y., Buffalo, N.Y., Austin, Tex., Louisville, Ky., and at St. Louis, Mo. (Washington University). The University of Washington School of Social Work, Seattle, holds summer classes both for child-care workers and for supervisors. The University of Wisconsin offers four 2-day seminars each year in addition to a sequence of four 17-session courses.

The number of schools of social work offering courses is increasing. These are usually around 15 sessions in length. During the past 2 years, the University of Tennessee School of Social Work has initiated a program of houseparent training with basic courses being offered in four cities. During the 1966–67 academic year, it will offer, in addition, two "advanced" courses and another basic course in a fifth locality. The Hunter College School of Social Work and the Columbia University School of Social Work have been giving courses for many years.

The University of Wisconsin this year introduced still another type of instruction, a correspondence sequence, with the first course entitled "Institutional Care for Children and Youth."

In the summer of 1965, to test the feasibility of prevocational training, the Houseparent Training Committee of the Welfare Council of Chicago and the Jane Addams School of Social Work conducted a 10-week demonstration project, giving full-time training to 23 students, including fieldwork.

All these activities indicate that there is movement and imagination in the direction of better training for child-care workers. These efforts will be strengthened when institutions themselves take greater responsibility for more consistent inservice training.

Surely all these efforts add up to something important—a gain not only in knowledge and insight on the part of child-care workers but also in a sense of recognition and feeling of identification with child care as a developing profession.

Eva Burmeister
Milwaukee, Wis.

CHILMAN: *Use of statistics*

"Although 'a little knowledge is a dangerous thing', not using that which we have been can be even more dangerous. But the use must be guided by wisdom." These are the closing words of the article by Dr. Catherine S. Chilman. ["Some Differences Between People and Statistics," CHILDREN, May–June 1966.] It is unfortunate that the author was apparently more concerned with the dangers of not using what she had than with being guided by wisdom.

On page 102, Dr. Chilman states that ". . . a measurement of . . . variability [is] commonly called the variance or standard deviation. . . ." I will not dispute this interesting assertion, although persons holding this view might be interested to learn that statisticians commonly call the standard deviation the square root of the variance.

On page 103, the author asserts that ". . . one point needing emphasis is that the *size* of a sample is generally not so important as the method of *choosing* a sample." The knottier problem of "choosing" is immediately solved in the following sentence. "Studies are far more likely to tell something about a group of people in general if investigations are planned in such a way as to provide for a *random* sample. . . ." This is a gross oversimplification, the extent of which can be gauged easily by reference to any standard text on sampling.

Sample method, sample size, and variance are in fact interdependent. The variance itself may be a very misleading statistic when the population is not normally distributed.

The discussion of statistical and practical significance on page 101 is also misleading. The level at which statistical significance is established is a statistician's tool that can be misused like any other tool requiring skill to operate. In proper hands it can save a tremendous amount of time in the research process. If one found a characteristic under investigation to be three times as prevalent in group A as in group B and that this difference was significant at the level specified, this should, I would think, be suggestive in pursuing further research. Whether most of the group exhibits this characteristic is beside the point.

As a practitioner I am quite aware of potential pitfalls in the use and abuse of statistical analysis. Warnings coupled with substantial abuses of their own hardly help the cause of statistics, research, or, in the final analysis, people.

Marvin M. Engel
Director of Research and Statistics
National Travelers Aid Association
New York

Author's reply

Mr. Engel makes some excellent points in his letter, all of them valid. The points are of particular relevance to persons who are specializing in the field of research and statistics. The

article was addressed to practitioners and represented an attempt to translate a very complex subject into a readily understandable one for nonresearchers whose job it is to use research findings in program development and practice in the health and welfare fields.

In reference to Mr. Engel's discussion of statistical significance, I attempted to make the point that statistically significant findings have a different set of meanings for researchers than for practitioners. Researchers, very properly, are seeking basic knowledge; practitioners, very properly, are seeking implications from research for action programs. For the practitioner, findings that apply to majorities *do* have pragmatic meaning, though this is not necessarily an essential for the researcher.

I am grateful to Mr. Engel for raising some important issues for further clarification.

Catherine S. Chilman
Social Science Analyst
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guides and reports

EDUCATING THE TEENAGER IN HUMAN RELATIONS AND MANAGEMENT OF RESOURCES. American Home Economics Association, 1600 20th Street NW., Washington, D.C., 20009. 1965. 107 pp. $1.

Eighteen selected papers and discussion summaries from the 1965 annual meeting of the American Home Economics Association.

TULSA CHILD HEALTH STUDY: report of health service. Child Health Study Committee, Tulsa, Okla. Coordinated by the Tulsa Council of Social Agencies in cooperation with the Division of Maternal and Child Health, Oklahoma State Department of Health; and Region VII, Department of Health, Education, and Welfare, Children's Bureau, Dallas, Tex. February 1966. 133 pp. Single copies free upon request (while they last) from the Tulsa Council of Social Agencies, 602 South Cheyenne Street, Tulsa, Okla., 74119.

Includes the reports of nine consultants who participated in a study of the maternity and child health services in Tulsa and their recommendations for improvement.

MENTAL ABILITIES OF CHILDREN FROM DIFFERENT SOCIAL-CLASS AND CULTURAL GROUPS. Gerald S. Lesser, Gordon Fifer, and Donald H. Clark. Monographs of the Society for Research in Child Development, University of Chicago Press, 5750 Ellis Avenue, Chicago, Ill., 60637. Vol. 30, No. 4, 1965. 115 pp. $3.

Examines differences in both the level and pattern of scores for four types of mental ability (verbal, reasoning, numerical, and space conceptualization) in first-grade children from four different ethnic backgrounds (Chinese, Jewish, Negro, and Puerto Rican), divided into middle and lower social class groups. The authors report that both social class and ethnicity and their interaction seem to affect intellectual performance, but suggest that more nearly precise testing procedures, free of class or cultural bias, are needed.

EQUALITY THROUGH INTEGRATION: a report on Greenburgh School District No. 8. Naomi and Arnold Bucheimer. Anti-Defamation League of B'nai B'rith, 315 Lexington Avenue, New York, 10016. 1965. 71 pp. $1.50.

An analysis of the 15 years' experience of complete racial integration in a public school district in Westchester County, N.Y., where specific programs were based on groupings, balanced in both race and ability, and curriculum designed to determine, develop, and challenge each child's ability.

RESEARCH IN SOCIAL FUNCTIONING IN HEALTH AND ILLNESS: An Annotated Bibliography. Lynda L. Holmstrom and William T. Hall. Social Research Program in Heart Disease, Division of Clinical Social Work, Stanford University School of Medicine, 300 Pasteur Drive, Palo Alto, Calif., 94304. 1965. 16 pp. Single copies available free on request from the Director, Social Research Program in Heart Disease.

The 270 books and articles included in this bibliography are listed under six groupings: concepts of health and disease; the patient's reaction to medical procedures and hospitalization; the impact of disease and disability on the patient; the patient's family; society's reaction to illness and disability; and methodology.

INFANT AND PRESCHOOL MENTAL TESTS: review and evaluation. Leland H. Stott and Rachell S. Ball. Monographs of the Society for Research in Child Development, University of Chicago Press, 5750 Ellis Avenue, Chicago, Ill., 60637. Vol. 30, No. 3, 1965. 151 pp. $3.

Reports on a project to determine and evaluate the types of devices and methods being used to test the mental ability of infants and preschool children.

ADVANCES IN PLANNED PARENTHOOD: proceedings of the annual meeting of the American Association of Planned Parenthood Physicians, April 29–30, 1964, Dallas, Tex. Edited by Aquiles J. Sobrero and Sarah Lewit. Schenkman Publishing Company, Inc., One Story Street, Cambridge, Mass., 02138. 1965. 151 pp. $5.95.

The 16 papers included here discuss problems of planned parenthood clinics and research in fertility control, planned parenthood programs in public health and welfare agencies, and research and experience with methods of fertility control.

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U.S. Government Publications

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QUEST FOR EQUALITY: the story of how six institutions opened their doors to serve Negro children and their families. Martin Gula. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Publication No. 441. 1966. 50 pp. 60 cents.

This publication presents principles for racially desegregating an institution previously open only to white children—from the planning stages, through preparation of staff, children, parents, and the neighboring community, to dealing with ensuing difficulties.

The principles are illustrated in case reports on the racial integration of children and staff in six previously segregated institutions written by their administrators—institutions for dependent, neglected, retarded, and disturbed children, and adolescent unwed mothers.

RARE INBORN ERRORS OF METABOLISM IN CHILDREN WITH MENTAL RETARDATION. Donough O'Brien, M.D. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Publication No. 429. 1965. 100 pp. 70 cents.

Directed to pediatricians and other professional persons concerned with mental retardation, this publication, divided into two parts, focuses its attention mainly on those rare metabolic disorders in children associated with mental retardation that require laboratory diagnoses because of ill-defined physical signs. Part I presents brief up-to-date clinical and laboratory findings, diagnostic and screening tests, and summaries of available information on the biochemistry, genetics, and treatment of these disorders. Part II presents a detailed description of technical procedures for diagnosing these disorders.

SOME FACTS AND FIGURES ABOUT CHILDREN AND YOUTH. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. 1966. 19 pp. Single copies available from the Bureau without charge.

Through answering 53 questions relating to the health and welfare of children and youth, this pamphlet presents statistics on child population, families living in poverty, infant and childhood mortality, and juvenile delinquency; information on maternal and child health, crippled children's, and child welfare services, and laws relating to child abuse and phenylketonuria; and the amounts of congressional authorizations and appropriations for Children's Bureau programs.

LEGAL BIBLIOGRAPHY FOR JUVENILE AND FAMILY COURTS. William H. Sheridan and Alice B. Freer. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. 1966. 46 pp. 35 cents.

Lists 400 selected articles, case decisions, law reviews, reports of conferences and programs, and other references on legal work with juvenile delinquents and with families—court administration and organization, criminal law and procedures, probation services, due process for juveniles, adoption and custody, the law and the indigent, and family courts and family law, among others. A supplement to this listing will be prepared annually.

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